

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Maryland Avenue				d. STREET ADDRESS 212 Maryland Avenue			
3. NAME OF DECEASED (Type or print) ESTHER ROSE BAKER				4. DATE OF DEATH Month September Day 12 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1876	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Somerset County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Raupach				14. MOTHER'S MAIDEN NAME Julia Shumaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Herbert J. Myers		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 334X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke DUE TO (c) Fitz's							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-5 , 19 58 , to 9-12 , 19 58 , that I last saw the deceased alive on 9-10-58 , and that death occurred at 1:30 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Johnson, Jr. M.D.				ADDRESS (Street, city or town, state) 16 Greene St. Cumberland Md 19-58			
PHYSICIAN'S NAME (Type) James T. Johnson, Jr.				DATE SIGNED 11-19-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9662

CERTIFICATE OF DEATH

Reg. Dist.

9662

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last BAKER				4. DATE OF DEATH Month SEPTEMBER Day 6 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 17, 1887	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		11. BIRTHPLACE (State or foreign country) W.VA.-Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD BAKER				14. MOTHER'S MAIDEN NAME ELIZABETH DONLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 6-17-1915 705-09-9815		17. INFORMANT Mrs. Mary L. Baker, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Congestive Heart Failure DUE TO 8 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, Cardiac Vascular Disease DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from Aug , 19 55 , to Sept , 19 58 , that I last saw the deceased alive on Sept 6 , 19 58 , and that death occurred at 9:03 A. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md DATE SIGNED 9/7/58 ACTUAL SIGNATURE G. Overton Himmelwright M.D. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-8-1958		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9665

CERTIFICATE OF DEATH

9660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DONALD Middle EDWARD Last BARNCORD				4. DATE OF DEATH Month SEPT. Day 11 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/48	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 9 Days 11 Hours 11 Min.		IF UNDER 24 HRS. Months 9 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME BARNCORD, WALTER				14. MOTHER'S MAIDEN NAME ELLIOTT, IRENE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (Retinoblastoma) 192x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 9/9 , 19 58 , to 9/11 , 19 58 , that I last saw the deceased alive on 9/11 , 19 58 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo N. Ley Jr.		M.D.		ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.		DATE SIGNED 9/12/58	
PHYSICIAN'S NAME (Type) DR. LEO LEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Report _____		Office of Registrar _____	



P9661

CERTIFICATE OF DEATH

Reg. Dist. No.

9721

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mineis Hospital</u>		e. STREET ADDRESS <u>Jackson Street</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Beeman</u> Middle Last		4. DATE OF DEATH <u>Sept 24</u> Month Day Year 19 <u>58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1958</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR: Months <u>23</u> Days <u>33</u> Hours <u>33</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Josephine Beeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Josephine Beeman</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545 Congenital Heart Defect</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 23</u> , 19 <u>58</u> , to <u>Sept 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 23</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOMC Lane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>9-24-58</u>	
PHYSICIAN'S NAME (Type) <u>WOMC Lane MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/24/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Moscow, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u> ADDRESS <u>Lonaconing, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2061191XV4

CERTIFICATE OF DEATH

1. Name of deceased: **James Alfred**

2. Date of death: **1911**

3. Place of death: **London, England**

4. Age at death: **19**

5. Cause of death: **George Thompson, London, England**

6. Name of informant: **James Alfred**

9731

CERTIFICATE OF DEATH

Reg. Dist. No.

09662

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lonaconing</u> <u>11X-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Daughter's home)</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>FLORENCE</u> Last <u>BROADWATER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Broadwater</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Broadwater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Verda Andrews, Barton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Years</u> <u>3 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gastro-enteritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 13, 1958</u> , to <u>Sept 20, 1958</u> , that I last saw the deceased alive on <u>Sept 20, 1958</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Sept 24, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Germany Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000



WILLIAM STATE DEPT

OFFICE OF THE SECRETARY

1912

WILLIAM STATE DEPT
OFFICE OF THE SECRETARY

WILLIAM STATE DEPT
OFFICE OF THE SECRETARY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09663

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>35 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d STREET ADDRESS <u>325 City View Terrace</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James L Brotemarkle</u>				4. DATE OF DEATH Month Day Year <u>Sept. 15, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 17, 1913</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M. RR</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clay Brotemarkle</u>		14. MOTHER'S MAIDEN NAME <u>Artie Diehl</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>705 10 3485</u>		17. INFORMANT <u>Rebecca Brotemarkle</u>		Address <u>Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Bronchogenic Carcinoma to Brain</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 15, 1958</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9667

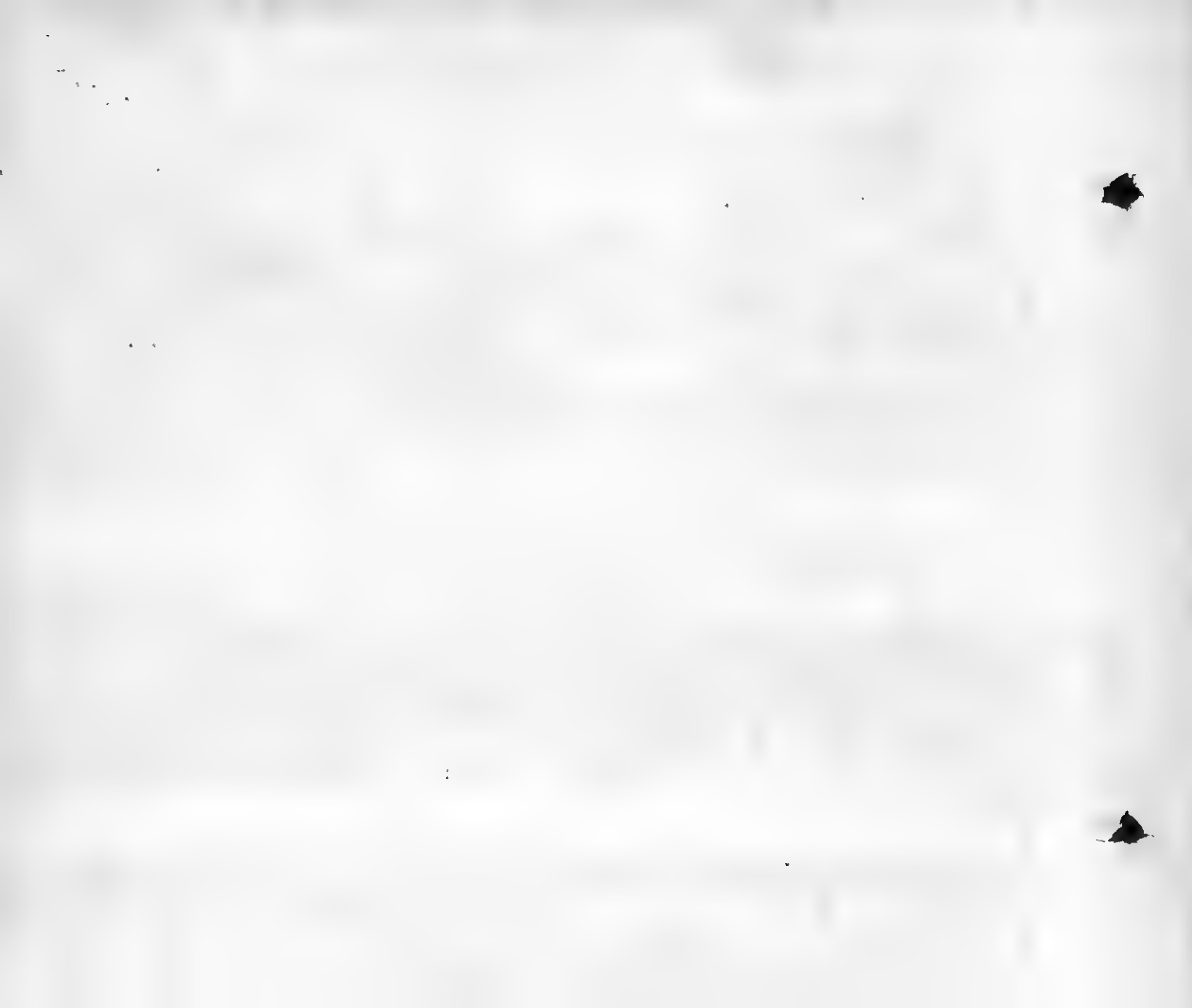
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 1103 OLDTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND		Middle JOSEPH		Last BROWN		4. DATE OF DEATH Month SEPTEMBER	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 19, 1916	
9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLINTON BROWN		14. MOTHER'S MAIDEN NAME MARY MANLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 214-07-6275		17. INFORMANT Mrs. Raymond Brown, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/19/58 , 19 58 , to 7/27/58 , 19 58 , that I last saw the deceased alive on 7/27/58 , 19 58 , and that death occurred at 7:03 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard J. Williams, M.D. 7/27/58							
ACTUAL SIGNATURE RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE William S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

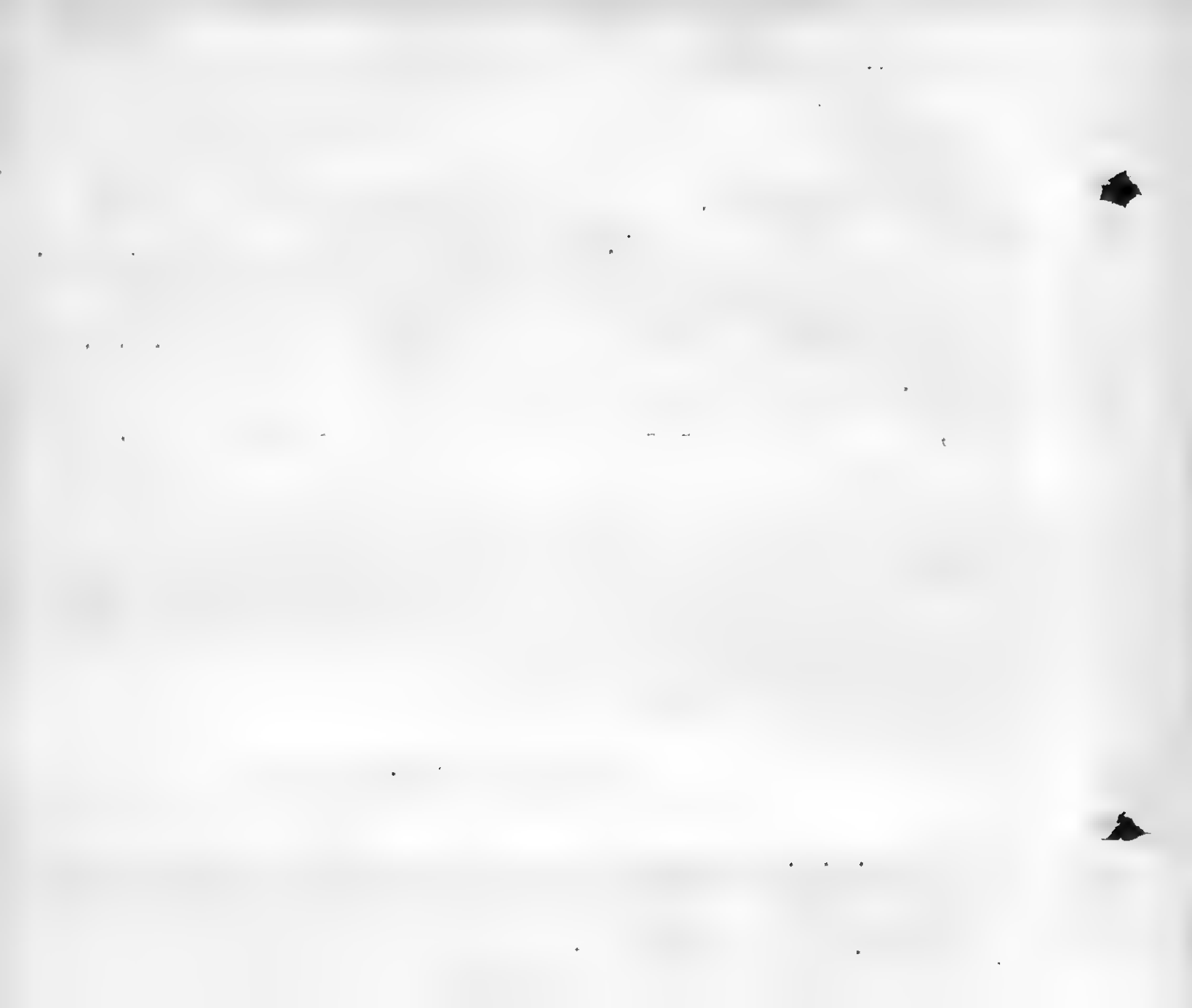
9668

CERTIFICATE OF DEATH

9665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle Estelle Last BROWNING		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 13, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY restaurant	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN H. SMITH		14. MOTHER'S MAIDEN NAME FLORENCE DE HAVEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 215-13-8884	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 260X DUE TO Chronic Hypertensive cardiac disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 years 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1952 to 9-15-1958 , that I last saw the deceased alive on 9-15-1958 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9-16-58			
ACTUAL SIGNATURE W. F. Williams		PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Smith	



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

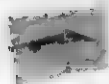
9732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		d. STREET ADDRESS		e. IS RES. DE. REC'D ON A F.R.M.P. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John S. Carr		4. DATE OF DEATH Month September Day 21 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 19-1883		9. AGE (In years last birthday) 75 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Carr		14. MOTHER'S MAIDEN NAME Elizabeth Matthews		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-03-9035A		17. INFORMANT Mrs. William Orr		Address Midland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation - Starvation DUE TO (b) Esophageal Carcinoma DUE TO (c) Silicosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland, Md.		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE W O McLane MD		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> asst		DATE SIGNED Sept 22 1958		EXAMINER'S NAME (Type) W O McLane MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		22e. (State)		22f. (County)		22g. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		24c. (City or town)		24d. (County)		24e. (State)	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB <u>Life</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. STREET ADDRESS <u>701 Elm Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>JACOB</u> Last <u>COUTER</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1958</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Couter</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Reid</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ruth Pardew</u>		Address <u>Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Sept 16, 1958</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9733 CERTIFICATE OF DEATH

Reg. Dist. No. 09668

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. LENGTH OF STAY IN 1b 43 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4	
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Crites		4. DATE OF DEATH Month September Day 1 Year 1958	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 19 1882
9 AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House wife	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Smith		14. MOTHER'S MAIDEN NAME Pamelia Clayton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Guy W. Crites		Address Olatown, Ind.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure 410X DUE TO Left Bundle Branch Block; Auricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Ventricular Hypertrophy DUE TO Mitral Insufficiency; Coronary Arteriosclerosis (c) Pulmonary Fibrosis		INTERVAL BETWEEN ONSET AND DEATH 7 weeks ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12 , 19 58 , to September 1 , 19 58 that I last saw the deceased alive on August 27 , 19 58 , and that death occurred at 2:29 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel M. Jacobson M.D.		ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 9/2/58	
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Moorefield, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Charles S. Hand	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9670

CERTIFICATE OF DEATH

Reg. Dist. No. 9669

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 57 DAYS			
d. NAME OF HOSPITAL, HOME, OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
f. STREET ADDRESS 714 N. CENTRE STREET				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ERMA PAULINE DE VAULT				4. DATE OF DEATH Month Day Year SEPTEMBER 6 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1910	9. AGE (In years last birthday) 48 yrs.	10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Lovers Leap Service		11. BIRTHPLACE (State or foreign country) MIDLOTHIAN, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME DAVID BOND Bone			
14. MOTHER'S MAIDEN NAME MARGARET CONRAD				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. no				17. INFORMANT 714 N. Centre Street Harold DeVault, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cerebros DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CUMBERLAND				20g. (County) ALLEGANY		20h. (State) MARYLAND	
21. I certify that I attended the deceased from 7-11 , 19 58 , to 8-6 , 19 58 that I last saw the deceased alive on 8-6 , 19 58 , and that death occurred at 2:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland, Md. DATE SIGNED 8-7-58							
ACTUAL SIGNATURE William P. James M.D.							
NAME (Type) WILLIAM P. JAMES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/1958		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR SEP 10 58		24b. REGISTRAR'S SIGNATURE William P. James	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9671

CERTIFICATE OF DEATH

Reg. Dist. No.

09670

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 450 N. Center St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Dreyer Last Dreyer				4. DATE OF DEATH Month 9 Day 5 Year 198			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-87	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Barnhill				14. MOTHER'S MAIDEN NAME Theresa Donnelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Marie Hill Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aplastic anemia							
292.4 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) / DUE TO							
(c) /							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from 4-3-1956 to 9-5-1958 , that I last saw the deceased alive on 9-5-1958 , and that death occurred at 7:30 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Levi Brings				DATE SIGNED 576 Green St. Cumberland Md 9-6-58			
PHYSICIAN'S NAME (Type) Byron Kight							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/1958		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 11 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

9672

CERTIFICATE OF DEATH

Reg. Dist. No.

09671

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. STREET ADDRESS <u>Box 211</u>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Darlene</u> Last <u>Duckworth</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>19 58</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/47</u>	9 AGE (In years last birthday) <u>11</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>		IF UNDER 24 HRS Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ernest Duckworth</u>				14. MOTHER'S MAIDEN NAME <u>Norma McCarty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Pt's chart.</u>		17. INFORMANT <u>Pt's chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoepithelioma, primary in nasopharynx,</u> DUE TO <u>with probable metastases to brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>few days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonia, left lower lobe</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>September 25 19 58</u> , to <u>September 29 19 58</u> , that I last saw the deceased alive on <u>September 26th, 19 58</u> , and that death occurred at <u>8:10 p.m.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D. <u>Algonquin Hotel, Cumberland, Md.</u>				PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/1/58</u>		<u>Philos.</u>		<u>Westernport Md</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Boal - Westernport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corrigansville	
c. LENGTH OF STAY IN 1b ██████████		d. STREET ADDRESS ██████████	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (DOA)			
3. NAME OF DECEASED (Type or print) First Clyde Middle Emerick Last Emerick		4. DATE OF DEATH Month Sept. Day 29 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee		12. IF UNDER 24 HRS. Hours 0 Min. 0	
13. FATHER'S NAME Lorenzo Emerick		14. MOTHER'S MAIDEN NAME Anna Kennell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7175	
17. INFORMANT Mrs. Ruth Emerick, Corrigansville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Coronary Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED Sept. 29, 1958	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Palo Alto Cemetery Hyndman, Pa. RD#1		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Heigler		24a. REC'D BY REGISTRAR OCT 2 1958	
ADDRESS Hyndman, Pa.		24b. REGISTRAR'S SIGNATURE W. L. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 3, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

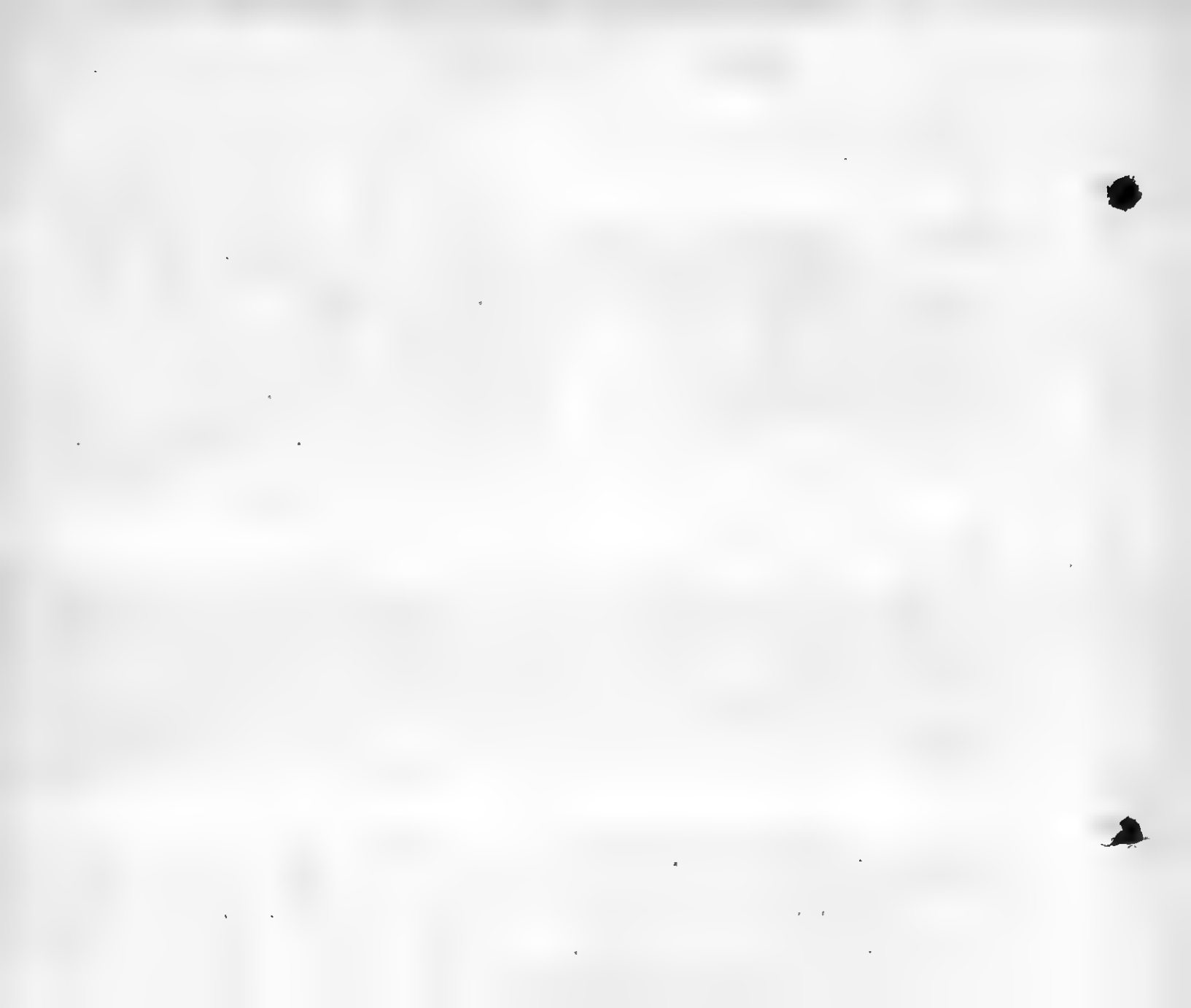
Reg. Dist. No. 9673

9674

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 9 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 901 MC MULLIN HIGHWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SUSAN LEE EVERHART		4. DATE OF DEATH Month Day Year SEPT. 3 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1958
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EVERHART, EDWIN L.		14. MOTHER'S MAIDEN NAME PHIPPS, BETTY S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) inashed prematurity DUE TO Possible cerebral hemorrhage & asp. pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-25-1958 to 9-3-1958 , that I last saw the deceased alive on 9-3-1958 , and that death occurred at 12:00 p. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 20 Greene St 9-4-58 ACTUAL SIGNATURE A. Hashim M.D. PHYSICIAN'S NAME (Type) DR. XXXXXXXXX A. HASHIM Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles I. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0675

CERTIFICATE OF DEATH

09674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN 1b <u>02 Cumberland,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>809 Sunbury Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>ELIZABETH</u> Last <u>FARRELL</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17,</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1975</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Rhinehart Shaffer</u>	
14. MOTHER'S MAIDEN NAME <u>Susan Dean</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No,</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Lee Duval 809 Sunbury Ave., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>269X</u> DUE TO (b). (c). <u>Cerebral of Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Diabetes Mellitus. Chronic Myocarditis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-10-1958</u> to <u>9-17-1958</u> that I last saw the deceased alive on <u>9-10-1958</u> and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>169 General St Cumberland Md 21510</u>	
ACTUAL SIGNATURE <u>J. J. Johnson</u> M.D.		DATE SIGNED <u>169 General St Cumberland Md 9-17-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. George</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9676

CERTIFICATE OF DEATH

Reg. Dist. No. 09675

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 334 N. MECHANIC STREET			
3. NAME OF DECEASED (Type or print) First MARTHA Middle IRENE Last FOLK				4. DATE OF DEATH Month SEPTEMBER Day 20 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 29, 1922	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House				10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) DAVIS, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CLAUDE WEAVER				14. MOTHER'S MAIDEN NAME Clara Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO None		17. INFORMANT Memorial Hospital, Cumberland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis Generalis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno Carcinoma Cervix DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19____, to 20 Sept , 19 58 , that I last saw the deceased alive on 20 Sept , 19 58 , and that death occurred at 11:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Fuller B Whitworth MD				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 22 Sept 58			
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept 23/58		Zion Memorial Burial Park		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Pyron Knight				ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

Reg. Dist. No.

19678

9677

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/15/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 28 Greene Street	
3. NAME OF DECEASED (Type or print) First Clara Middle B. Last Frost		4. DATE OF DEATH Month September Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1865
9. AGE (In years last birthday) yrs. 92		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rawlings, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel A. Porter		14. MOTHER'S MAIDEN NAME Sarah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 444.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis (c) hypertension, coronary artery disease, heart		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15/56 , 19 to 9/22/58 , 19, that I last saw the deceased alive on 9/22/58 , 19, and that death occurred at 6:50 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur S. Kraus		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
DATE SIGNED 9/23/58			
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9678

CERTIFICATE OF DEATH

09677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 35 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS VALLEY RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON E. FULLER				4. DATE OF DEATH Month Day Year SEPT. 3 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1873		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railway Express Co.		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FULLER, HOWARD				14. MOTHER'S MAIDEN NAME RIZER, MARY MARTHA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Coronary Arteriosclerosis Myocarditis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis and Anemia							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/8/56 , 19____, to 9/3/58 , 19____, that I last saw the deceased alive on 9/3/58 , 19____, and that death occurred at 2:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9/3/58			
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Charles S. Haas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

9679 CERTIFICATE OF DEATH

09678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle GOTTLIEB Last GOTTLIEB		4. DATE OF DEATH Month SEPTEMBER Day 11 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant.		10b. KIND OF BUSINESS OR INDUSTRY (Nothing)	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NEHEMIAS GOTTLIEB		14. MOTHER'S MAIDEN NAME DEBORAH OTTENHEIMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Miss Mellic Gottlieb		Address Cumb Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis & myocardial DUE TO (c) hypertension			
INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 7 , 19 58 , to Sept 11 , 19 58 , that I last saw the deceased alive on Sept 10 , 19 58 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. M. Schindler M.D.		DATE SIGNED 43 Everett Ambler 27-11-58	
PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/14/58	East View Cem.	Cumb. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb Md	
24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G24, 10/6/58 fcy

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> 9734		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lonaconing</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lonaconing</i>	
c. LENGTH OF STAY IN 1b <i>40</i>		d. STREET ADDRESS <i>Castle Hill</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RES. MADE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alexander</i> Middle <i>Gowan's</i> Last <i>Gowan's</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>30</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 12 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Coal Miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Coal Mines</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Gowan's</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Gibson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>First World War</i>		16. SOCIAL SECURITY NO. <i>217-03-5896</i>	
17. INFORMANT <i>Mrs Alexander Gowan's - Lonaconing</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Dilatation</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Myocardial Insufficiency</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>4 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W.O. McLane</i>		DATE SIGNED <i>Sept 30 1958</i>	
EXAMINER'S NAME (Type) <i>W.O. McLane</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Asst</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 3, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Frostburg, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Eichhorn</i>		ADDRESS <i>Lonaconing, Md</i>	
24a. REC'D BY REGISTRAR <i>2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9680

CERTIFICATE OF DEATH

09680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/7/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
f. STREET ADDRESS 202 Grand Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Green		4. DATE OF DEATH Month September Day 18, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1885
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerk	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Green		14. MOTHER'S MAIDEN NAME Margaret Crosser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-05-8924	
17. INFORMANT P. O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertension 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arterio Sclerosis, Duodenal DUE TO (c) Psychosis, Acute		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7/58 19__ to 9/18/58 19__, that I last saw the deceased alive on 9/18/58 19__, and that death occurred at 5:10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/19/58			
ACTUAL SIGNATURE R. Mathews M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/19/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-22-58	22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 23 1958		24b. REGISTRAR'S SIGNATURE James F. Scarpelli	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09681

9735

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale	c. LENGTH OF STAY IN 1b years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 National Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edna Marie Hartsock		4. DATE OF DEATH Month Day Year Sept. 26, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1894
9. AGE (In years lost birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Meshack Richards	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Valentine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO 220-07-6260		17. INFORMANT Mrs. Jas. C. Kidd, LaVale, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction after cerebral hemorrhage, postcardiac arrest INTERVAL BETWEEN ONSET AND DEATH 2 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1948 to Sept. 26 1958 , that I last saw the deceased alive on August 27 1958 , and that death occurred at LaVale, Md. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Elizabeth Brings		DATE SIGNED 9/28/58	
PHYSICIAN'S NAME (Type) Elizabeth Brings M.D.		Greene Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 29, 1958	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE OCT 1 '58	24b. REGISTRAR'S SIGNATURE C. J. S. Jones

9681

CERTIFICATE OF DEATH

09682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 20 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle C. Last Hines				4. DATE OF DEATH Month 9 Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1900	
9. AGE (In years last birthday) 57 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		11. BIRTHPLACE (State or foreign country) Woodstock, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Hines				14. MOTHER'S MAIDEN NAME Clara Virts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 214-05-8946		17. INFORMANT Mrs Allie Hines		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease 4. 0. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 9/8 , 19 58 to 9/9 , 19 58 that I last saw the deceased alive on 9/8 , 19 58 , and that death occurred at 9/9 , 19 58 , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler				DATE SIGNED 9/11/58			
PHYSICIAN'S NAME (Type) Dr. B.M. Schindler				ADDRESS 43 Greene Street			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 12 1958		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem		22d. LOCATION (City, town, or county) Cumberland (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9682

CERTIFICATE OF DEATH

Reg. Dist. No.

09683

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE KEYSER b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.				d. STREET ADDRESS 138 WEST PIEDMONT STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VIOLA Middle MAUDE Last HOLLEN				4. DATE OF DEATH Month SEPTEMBER Day 11 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 30 1897	
9. AGE (In years last birthday) yrs 60		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Representative C. & P. Tel. Co				10b. KIND OF BUSINESS OR INDUSTRY KEYSER, W. VA.			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ROBERT E. LEE HOLLEN				14. MOTHER'S MAIDEN NAME DORA MAE DE WITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 233-10-1763		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Verticillate Infection 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Cardiovascular DUE TO (c) Cholecystectomy 9-3-58 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE CRIMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Months Wangyys							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-25, 19 58 to 9-10, 19 58 that I last saw the deceased alive on 9-9, 19 58 and that death occurred at 1:10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 9-12-58							
ACTUAL SIGNATURE W. F. Williams M.D.							
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/58		22c. NAME OF CEMETERY OR CREMATORY Terra Alta		22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Smith				ADDRESS Keyser W. Va.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9683

CERTIFICATE OF DEATH

Reg. Dist. No.

09684

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Holliday</u> Last <u>Holliday</u>		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/1879</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>19</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mc Donald</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Oss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, with Myocardial Degeneration & Infarction</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> Years _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease, with infarction and congestive failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August 30, 1958</u> to <u>September 8, 1958</u> , that I last saw the deceased alive on <u>September 7, 1958</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Maryland.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. W. F. Doerner, Jr.</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9736

CERTIFICATE OF DEATH

09685

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. #2, Zihlman		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D.#2 Box 172, Zihlman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frostburg				d. STREET ADDRESS Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie G. Howsare				4. DATE OF DEATH Month Day Year 9 24 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/1880		9. AGE (In years lost birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Porter				14. MOTHER'S MAIDEN NAME Mahala Crowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes give year or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Eleanor Howsare, R.D.#2, Box 172, Frostburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 4400 DUE TO arterio Sclerotic Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Insular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Cholecystitis							INTERVAL BETWEEN ONSET AND DEATH 3 days several years
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21 , 19 58 , to Sept 24 , 19 58 , that I last saw the deceased alive on Sept 24 , 19 58 , and that death occurred at 12:45 P. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED Sept 26 1958							
ACTUAL SIGNATURE WOM Lane		M.D. WOM Lane					
PHYSICIAN'S NAME (Type) WOM Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-58		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B.H. Montesant				24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

9684

CERTIFICATE OF DEATH

09686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 42 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Maryland Ave.				d. STREET ADDRESS 903 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walker Sanford Huff				4. DATE OF DEATH Month Day Year 9 10 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1880		9. AGE (In years last birthday) 78 yns.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brick Company		11. BIRTHPLACE (State or foreign country) Twiggstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elisha Huff				14. MOTHER'S MAIDEN NAME Anna Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-05-6111		17. INFORMANT Address Mrs. Madline Huff, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Thaemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis & Decompensative DUE TO 8 min (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1958 to Sept. 10, 1958 , that I last saw the deceased alive on Aug. 15, 1958 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay Durrett		M.D. Cumberland, Md.		ADDRESS (Street, city or town, state) 9/10/58		DATE SIGNED 9/10/58	
PHYSICIAN'S NAME (Type) Dr. Clay Durrett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-58		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery Cumberland, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

9722

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>				TOWN <u>Mount Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>William Henry Imes</u>				<u>Sept. 10, 1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 8, 1903</u>	<u>55</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Brakeman</u>		<u>WM Railway</u>		<u>Mt. Savage, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Henry Imes</u>				<u>Rebecca Winfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Lost</u>		<u>Dorothy G. Imes, Mt. Savage, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>1 Day</u>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 10, 1958</u> to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 10, 1958</u> , and that death occurred at <u>3:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>WOMC Lane</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>Sept 10 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 13, 1958</u>		<u>Methodist Cemetery</u>		<u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>SEP 16 '58</u>		<u>Arthur S. Kraus</u>		<u>Lawrence L. Lightner</u>		<u>Hyndman, Pa.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1
The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



09688

9737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Dawson, Md.		c. LENGTH OF STAY IN 1b 34 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dawson, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Iser		4. DATE OF DEATH Month September , Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Aug 1875
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 83 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Iser		14. MOTHER'S MAIDEN NAME Rebecca Iser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Leonard Iser		Address Keyser, R.F.D. 3 W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH May 1958	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 58 , to Sept 25 , 19 58 , that I last saw the deceased alive on Sept 25 , 19 58 , and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Keyser, W. Va. DATE SIGNED Keyser, W. Va.			
ACTUAL SIGNATURE T.C. Giffin M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 28 Sept 1958	22c. NAME OF CEMETERY OR CREMATORY Dayton Cemetery	22d. LOCATION (City, town, or county) (State) Allegany County Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Allen M. Kistner		24a. REC'D BY REGISTRAR SEP 29 '58	24b. REGISTRAR'S SIGNATURE John S. Kistner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9685 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RT. 2, HINKLE RD. CITY. CUMBERLAND, MD.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY C. JOHNSON				4. DATE OF DEATH Month Day Year SEPT. 15, 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 13, 1886		9. AGE (in years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance work		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-05-7334		17. INFORMANT Address SON DAVID, 309 COLUMBIA ST. CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2 , 19 58 , to 9/15 , 19 58 , that I last saw the deceased alive on 9/15 , 19 58 , and that death occurred at 3:50 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 413 N. Centre St. DATE SIGNED 9/16/58							
ACTUAL SIGNATURE Leo H. Ley Jr M.D.		PHYSICIAN'S NAME (Type) LEO H. LEY JR Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept.; 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

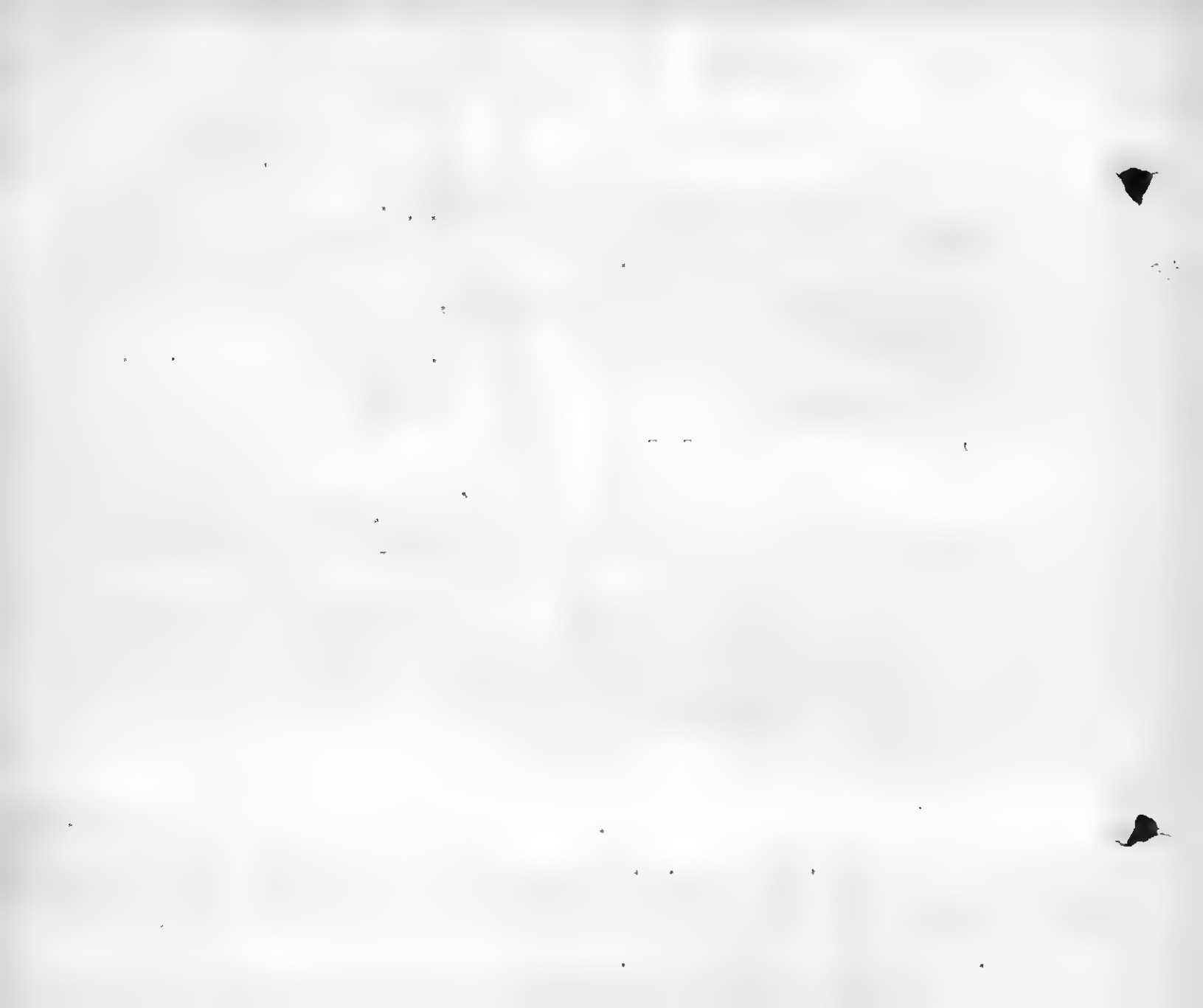
9686

CERTIFICATE OF DEATH

09690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS Bedford Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle Henry Last JOHNSON				4. DATE OF DEATH Month SEPT Day 6 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1892		9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well driller				10b. KIND OF BUSINESS OR INDUSTRY Well Drilling		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME SAMUEL JOHNSON				14. MOTHER'S MAIDEN NAME Mary Leigh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO (If yes, give year or dates of service) 217-10-6184		17. INFORMANT DAUGHTER NELLIE TAYLOR, 311 PULASKI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage, right side Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO 5 days (c) 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-2-58 to 9-6-58 and that I last saw the deceased alive on 9-6-58 and that death occurred at 7:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James F. Johnson M.D. 16 Green St Cumberland Md 21738				DATE SIGNED 11-9-58			
PHYSICIAN'S NAME (Type) James F. Johnson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/58		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		22d. LOCATION (City, town, or county) (State) Near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR SEP 15 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09691

9687

Reg. Dist. No

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>401 Virginia Ave.</u>				d. STREET ADDRESS <u>229 Emily St.</u>			e. IS RE INTERRED ON A FARM. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie Lookabaugh Jones</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1958</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-1896</u>		
9. AGE (in years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		
13. FATHER'S NAME <u>John Lookabaugh</u>				14. MOTHER'S MAIDEN NAME <u>Mary Houck</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Rose Landis, Cumberland, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> DUE TO (b) <u>Skull Fracture</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>20 Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Sclerosis, Marked</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell down steps</u>				
20c. TIME OF INJURY Hour <u>11:00</u> p. m. Month <u>9</u> Day <u>9</u> Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cumberland, Alleg., Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 9, 1958</u>				DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetery</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clara E. Kenna</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9738

CERTIFICATE OF DEATH

Reg. Dist. No. 09692

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean, Rural (Frostburg), MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean, Rural (Frostburg), MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J Last JONES		4. DATE OF DEATH Month 9/4 Day 1958 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 13, 1872
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Frostburg, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Elizabeth -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Jones (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 1200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 19 78 , to Sept. 4 , 19 58 , that I last saw the deceased alive on September 4 , 19 58 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED 9/4/58	
PHYSICIAN'S NAME (Type) John B. Davis, M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/7/1958	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kana	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10a, Form G-234 10/7/58, sec.

9688

CERTIFICATE OF DEATH

10749

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b Lifetime	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Broadway Circle		d STREET ADDRESS 409 Broadway Circle	
3 NAME OF DECEASED (Type or print) First Harvey Middle C. Last Lewis		4 DATE OF DEATH Month 9 Day 24 Year 1958	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 28, 1881
9 AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Boilermaker helper Charles Lewis		14. MOTHER'S MAIDEN NAME Anna Kline	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Harvey C. Lewis, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23-58 , 19 to 9-24-58 , 19, that I last saw the deceased alive on 9-24-58 , 19, and that death occurred at 10 p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 9-26-58	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF 9-29-58	22c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d LOCATION (City, town, or county) (State) Cumberland, Md.
23 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a REC'D BY REGISTRAR 9-30-58		24b. REGISTRAR'S SIGNATURE William S. Thayer	



9739

CERTIFICATE OF DEATH

09693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pier Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vernon Middle Clealean Last Liller		4. DATE OF DEATH Month Sept. Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min 00	11. IF UNDER 24 HRS Hours 15 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Contractor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	11. BIRTHPLACE (State or foreign country) Burlington, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John W. Liller	
14. MOTHER'S MAIDEN NAME Elisha Blackburn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Conda Smith Rawlings, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung (Left) 105X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 months (c) Interval between onset and death		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension C.V. Disease 2-3 years		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 43 Greene St.,	
20e. (City or town) Cumberland, Md.		20f. (County) Cumberland	
20g. (State) Md.		20h. (City or town) Rawlings	
21. I certify that I attended the deceased from July 13, 1957 to Sept 15, 1958 and that death occurred at 8:00 P.M. from the causes and on the date stated above.		22. I last saw the deceased alive on Sept 13, 1958	
ACTUAL SIGNATURE B. M. Schindler M.D.		DATE SIGNED SEP 18 '58	
PHYSICIAN'S NAME (Type) Blaine M. Schindler M. D.		ADDRESS Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery	22d. LOCATION (City, town, or county) (State) Near Rawlings, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. 1	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 164 BEDFORD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle LONGCAREVICH Last LONGCAREVICH		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1888
9. AGE (In years lost birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Maintenance		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR	
11. BIRTHPLACE (State or foreign country) YUGGOSLAVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LONGCAREVICH, Teodor		14. MOTHER'S MAIDEN NAME KRUNIC, Sofija	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705 07 6677	
17. INFORMANT Mrs. May Longcarevich, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT TONSILLAR PILLAR DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 25 , 19 58 , to SEPT , 19 58 , that I last saw the deceased alive on SEPT 25 , 19 58 , and that death occurred at 6:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank Cawley M.D. PHYSICIAN'S NAME (Type) DR. FRANK CAWLEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 29, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE C. S. Kuntz	

[Faint handwritten notes]

72 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

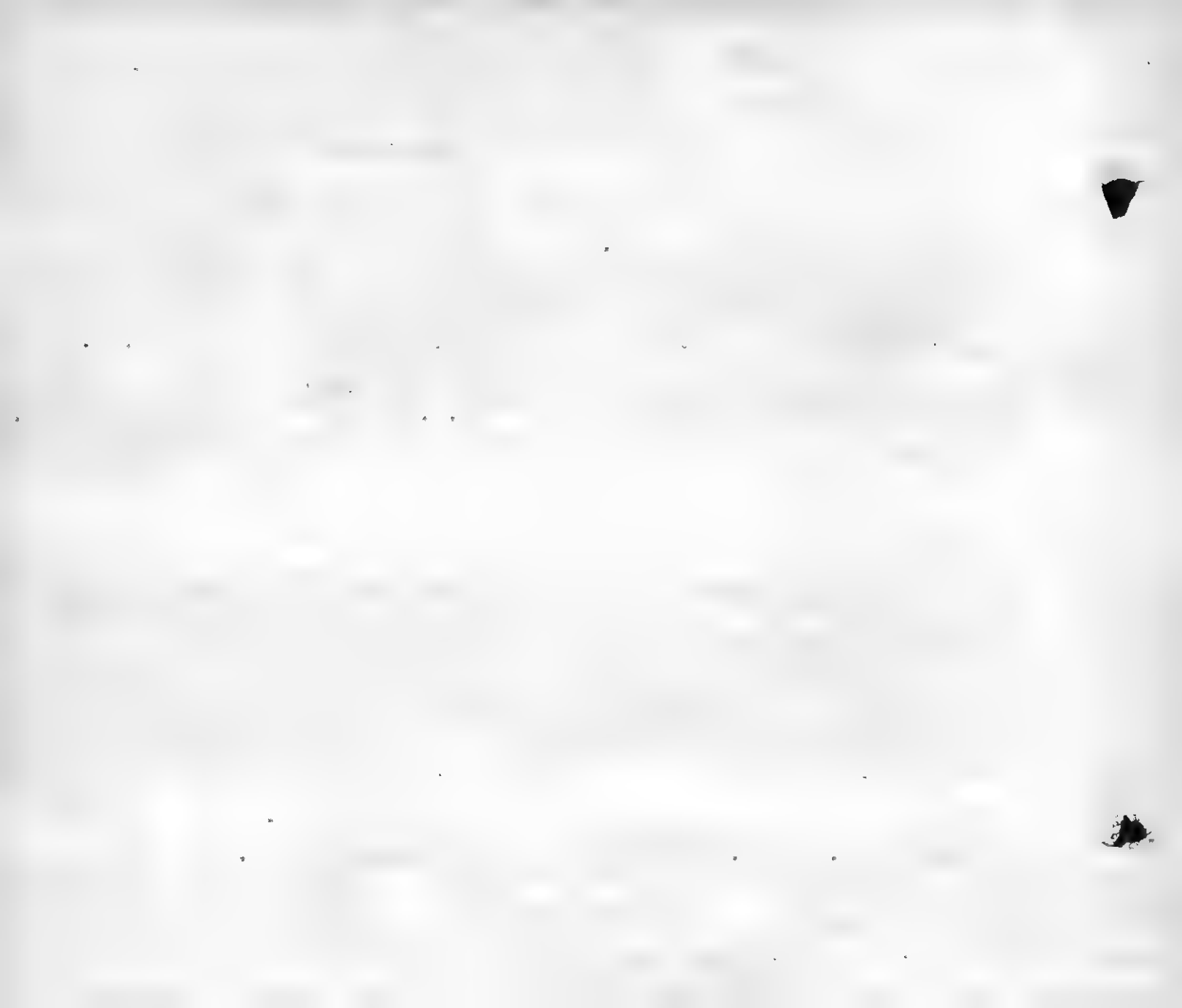
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9690

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/20/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 509 Eastern Avenue	
3. NAME OF DECEASED (Type or print) First Lucy Middle M. Last Lowery		4. DATE OF DEATH Month September Day 24 Year 19 58	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1875
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Lowery		14. MOTHER'S MAIDEN NAME Mary Ann Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, severe 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis, atherosclerosis DUE TO (c) Terminal condition, extension of atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20/58 , 19___, to 9/24/58 , 19___, that I last saw the deceased alive on 8/23/58 , 19___, and that death occurred at 8:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/24/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		ADDRESS Cumberland, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/58	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Bedford Pa Rt #3
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR SEP 26 '58		24b. REGISTRAR'S SIGNATURE Carlton S. House	



9691

CERTIFICATE OF DEATH

Reg. Dist. No. 09696

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Windsor Hotel</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Luteman</u>				4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/93</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>	IF UNDER 24 HRS Hours <u>5</u> M.n. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Ross Luteman</u>				14. MOTHER'S MAIDEN NAME <u>Florence Dougherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W. I 213-16-9942</u>		17. INFORMANT <u>Mrs. Agnes Peters Portsmouth, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 5, 1958</u> to <u>Sept 5, 1958</u> , that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u></u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>43 Green St. Cumberland Md.</u> DATE SIGNED <u>9/6/58</u>							
ACTUAL SIGNATURE <u>B. M. Schindler M.D.</u>							
PHYSICIAN'S NAME (Type) <u>B. M. Schindler, M.D. 42 Duane St. Cumberland Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				ADDRESS <u>Cumberland Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>10/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>William E. Haas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9740

CERTIFICATE OF DEATH

Reg. Dist. No.

09697

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 3 Keyser, W.Va.		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Keyser, W.Va.		e. STREET ADDRESS Route 3 Keyser, W.Va.	
3. NAME OF DECEASED (Type or print) First Ervin Middle Mace Last Mace		4. DATE OF DEATH Month Sept. Day 22 Year 19 58	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1890
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	11. IF UNDER 24 HRS Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Allegany Ballistics	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Mace		14. MOTHER'S MAIDEN NAME Hannah Ours	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-16-4593	
17. INFORMANT Carl Mace		Address Route 3 Keyser, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease (c) atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 9-22-58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-22-1958 to 9-22-1958 , that I last saw the deceased alive on 9-22-1958 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. S. [Signature] M.D.		ADDRESS (Street, city or town, state) 56 N. Main St. Keyser W.V.	
DATE SIGNED SEP 25 1958		DATE SIGNED SEP 25 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Meadow Point		22d. LOCATION (City, town, or county) (State) Keyser W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. [Signature]		24a. REC'D BY REGISTRAR Westernport, Md	
24b. REGISTRAR'S SIGNATURE William S. [Signature]		24c. REGISTRAR'S SIGNATURE William S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 & 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3692

CERTIFICATE OF DEATH

09698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.				d. STREET ADDRESS 328 Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle GRANT Last MACFARLANE				4. DATE OF DEATH Month Sept. Day 16 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23- 12/23/95	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Macfarlane				14. MOTHER'S MAIDEN NAME Elizabeth L. Grant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, W. W. # 1		16. SOCIAL SECURITY NO		17. INFORMANT Address Memorial Hospital, Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cholecystitis & Sepsis 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver - Hepatic Coma							INTERVAL BETWEEN ONSET AND DEATH 19 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 58 , to Sept , 19 58 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred on 10.10.58 , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Himmewright M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 133 W. Ave Cumberland Md 9/17/58			
PHYSICIAN'S NAME (Type) Dr. O. G. Himmelwright							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland				24a. REC'D BY REGISTRAR DA SEP 22 '58		24b. REGISTRAR'S SIGNATURE William E. Kline	

9693

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/18/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 154 Bedford Street, Cumberland	
f. STREET ADDRESS Cumberland, Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Florence Edith Martin		4. DATE OF DEATH Month Day Year September 6, 1958	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Martin		14. MOTHER'S MAIDEN NAME Barbara Fettes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOC. SEC. NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 572X DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last bilateral arteriosclerosis DUE TO Chronic Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH ? ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/18/58 19 to 9/6/58 19, that I last saw the deceased alive on 9/6/58 19, and that death occurred at 5:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 9/8/58			
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 9 1958	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23 FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE SEP 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

9723

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Bernard McConnell		4. DATE OF DEATH Month Sept Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 73 Days 73 Hours 73 Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Rail-road	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McConnell		14. MOTHER'S MAIDEN NAME Ann Showalter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 712-1401602	
17. INFORMANT Mrs. W.B. McConnell-Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate & metastasis to bone 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis to bone DUE TO (c) metastasis to bone PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastasis to bone		INTERVAL BETWEEN ONSET AND DEATH Month-	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20, 1958 , to September 21, 1958 , that I last saw the deceased alive on Sept. 20, 1958 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED 9/24/58	
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/58	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	22d. LOCATION (City, town, or county) (State) Moscow Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. J. B. B. B.		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9694

CERTIFICATE OF DEATH

09701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/6/58	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Algonquin Hotel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Frederick Last McEvoy		4. DATE OF DEATH Month September Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Real Estate Owner		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John D. McEvoy		14. MOTHER'S MAIDEN NAME Catherine Gramlich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6/58 , 19____, to 9/19/58 , 19____, that I last saw the deceased alive on 9/18/58 , 19____, and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 9/19/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		DATE SIGNED 9/19/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/22/58	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR SEP 23 1958		24b. REGISTRAR'S SIGNATURE Christ S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9695

CERTIFICATE OF DEATH

09702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 715 Hilltop Drive		d. STREET ADDRESS 715 Hilltop Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Ann Mellott		4. DATE OF DEATH Month Day Year 9 - 9 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1871
9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Orleans, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Clay		14. MOTHER'S MAIDEN NAME Mary Ann Fitzpatrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Rita Lyons, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO uraemia			INTERVAL BETWEEN ONSET AND DEATH 3 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO			5 yrs
(c) Arteriosclerotic C-V Disease			15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to Sept 10, 1958 , that I last saw the deceased alive on Aug 20, 1958 , and that death occurred at 9:10/58 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Clayton S. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9/10/58	
PHYSICIAN'S NAME (Type) Dr. Clay Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-1958	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09703

Reg. Dist. No.

9741

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frostburg				c. LENGTH OF STAY IN 1b X Rural Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Meyers				4. DATE OF DEATH Month September Day 14 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John McGowan				14. MOTHER'S MAIDEN NAME Mary Nolan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John Meyers		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND D.O.A. Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 14, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/58		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR SEP 16 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09704

9696

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS BOX 122			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES L. MILLER				4. DATE OF DEATH Month Day Year SEPT. 3 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) PENN. Glencoe		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MILLER, CONRAD				14. MOTHER'S MAIDEN NAME TRESSLER, MARGARET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3, 1958 to Sept 3, 1958 , that I last saw the deceased alive on Sept 3, 1958 , and that death occurred at 5:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas L. Wright M.D.				ADDRESS (Street, city or town, state) 13316 Ave, Cumberland Md			
PHYSICIAN'S NAME (Type) DR. HIMMELWRIGHT				DATE SIGNED 9/5/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest-Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hane	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09705

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>W. Va.</u> b COUNTY <u>Morgan</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u> d STREET ADDRESS <u>Fairfax St.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>D</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1958</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov 9, 1909</u>		9. AGE (in years last birthday) <u>48</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mutual Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Race Tracks</u>		11. BIRTHPLACE (State or foreign country) <u>Morgan Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>John M. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hester May</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give last 4 digits of service) <u>No</u>		17. INFORMANT <u>William H. Hunter</u> Address <u>Berkeley Springs, W. Va.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>m</u> p m <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED											
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 19, 1958</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u>		22d. LOCATION (City, town, or county) <u>Berkeley Springs, W. Va.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>						ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine S. Hume</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.



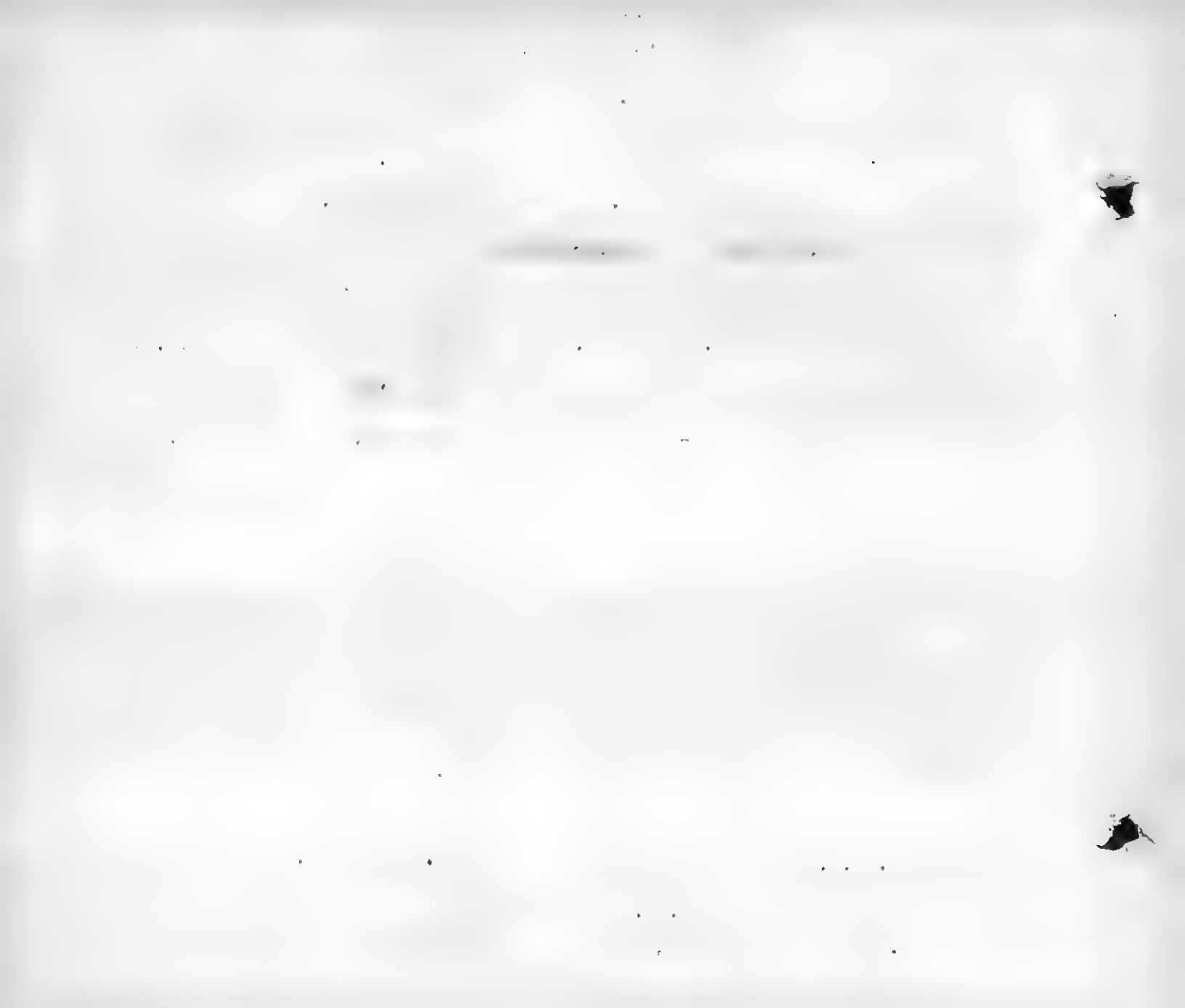
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9698

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN lb 10 minuts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.		d. STREET ADDRESS 413 Washington St.	
3. NAME OF DECEASED (Type or print) First Middle Last William Alexander Miller		4. DATE OF DEATH Month Day Year Sept. 16 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/02
9. AGE (In years lost birthday) yrs 55		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) array engineer		10b. KIND OF BUSINESS OR INDUSTRY Md. State Rls.	
11. BIRTHPLACE (State or foreign country) New Jersey, Patterson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Miller		14. MOTHER'S MAIDEN NAME Bessie Lamb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-4913	
17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism, upper lobe - 1951 & 2 lower lobes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-5-1947 to 9-16-1958 , that I last saw the deceased alive on 9-16-1958 , and that death occurred at 9:25 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED 122 So. Centre St., Cumberland, Md. 9-16-58			
ACTUAL Dr. W.F. Williams			
PHYSICIAN'S NAME (Type) Dr. W.F. Williams			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 9/19/58			
22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's			
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			
ADDRESS Cumberland, Maryland			
24a. REC'D BY REGISTRAR SEP 22 '58			
24b. REGISTRAR'S SIGNATURE Charles L. George			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9699

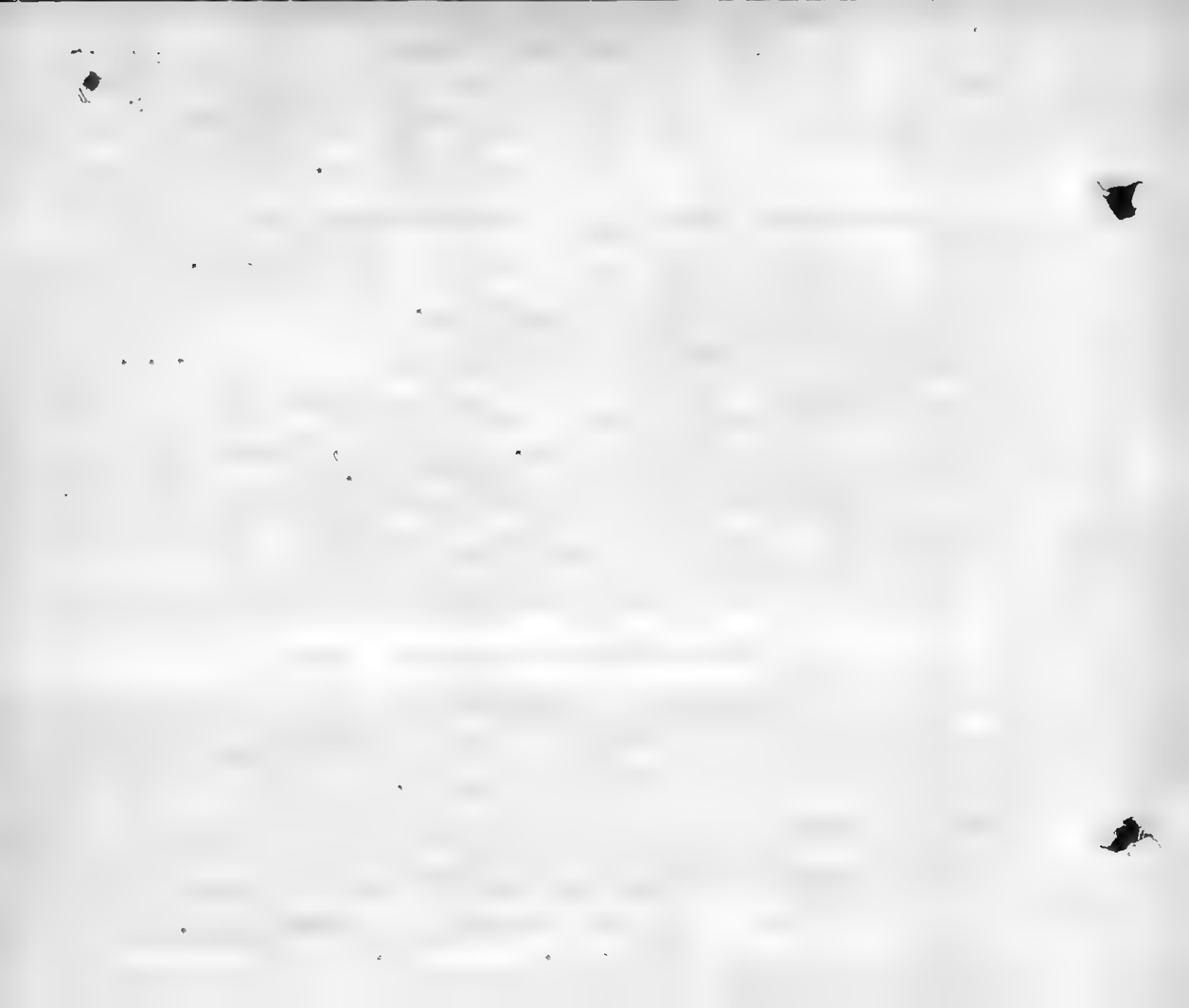
Item 8 Film 0233 9-15-58 at

CERTIFICATE OF DEATH

Reg. Dist. No.

09707

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle L Last MIRE		4. DATE OF DEATH Month Sept. Day 3rd. Year 1958 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5th. 1892
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram Coleman		14. MOTHER'S MAIDEN NAME Mary Jane Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Thomas Loar, Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Breast Metastasis to lungs 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 mo 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-12- , 19 52 , to 9-3- , 19 58 , that I last saw the deceased alive on 9-2- , 19 58 , and that death occurred at 7 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE P. Rhett Radbone M.D. 122 So Centre St Cumberland, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		24a. REC'D BY REGISTRAR SEP 8 '58	
ADDRESS LONA CONING, MD.		24b. REGISTRAR'S SIGNATURE C. L. S. Kraw	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

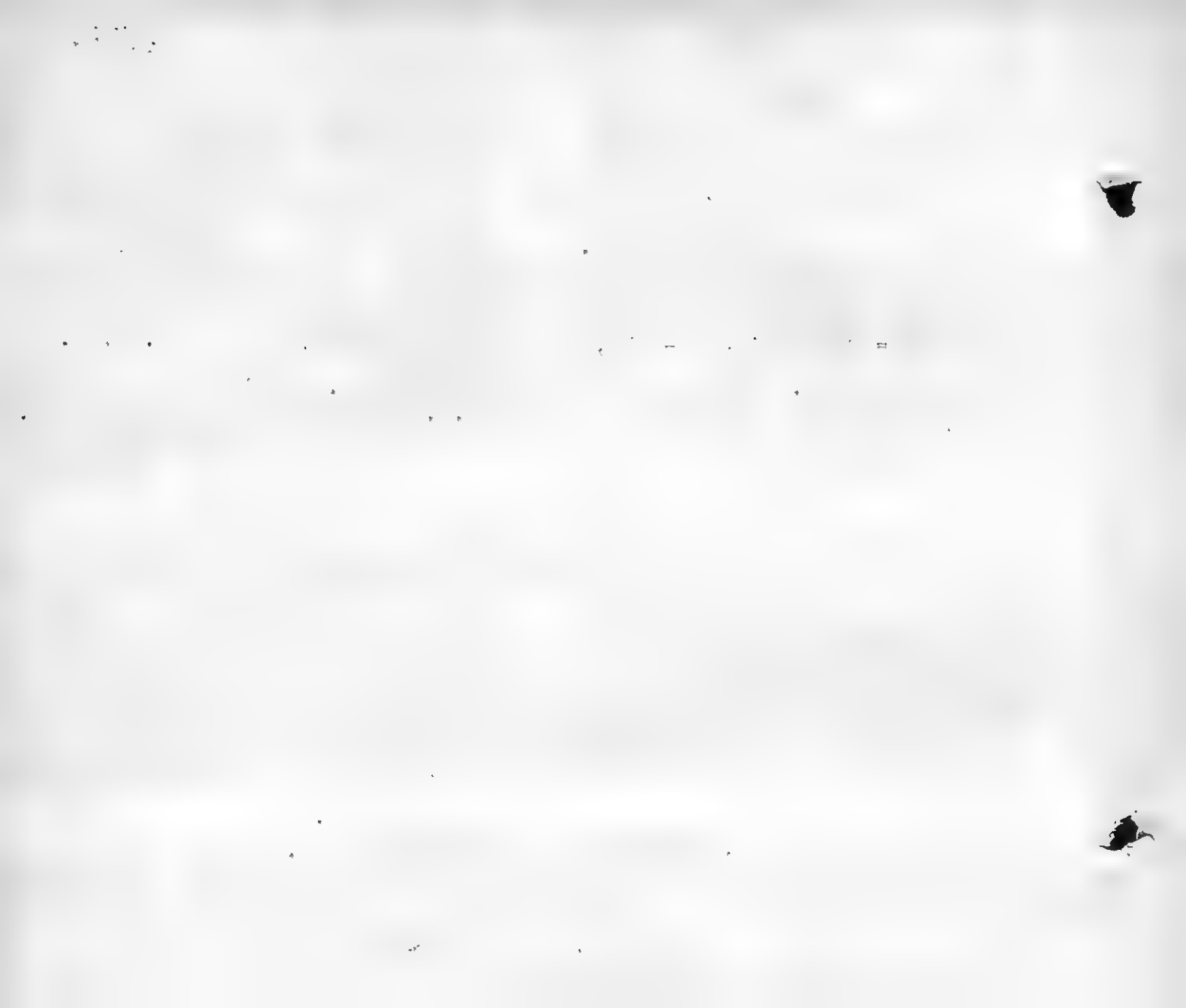
ALLEGANY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9700

CERTIFICATE OF DEATH

Reg. Dist. No. 09708

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 6/24/58	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 601 Shriver Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle M. Last Mullan		4. DATE OF DEATH Month September Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1871
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Steam Fitter - Plumber		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	11. BIRTHPLACE (State or foreign country) U. S. A.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John B. Mullan	
14. MOTHER'S MAIDEN NAME Catherine T. Petri		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, say on what date) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Chl. Scurie 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, long standing DUE TO (c) Scurie			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 6/24/58 , 19____, to 9/25/58 , 19____, that I last saw the deceased alive on 9/24/58 , 19____, and that death occurred at 2:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE L. Mathews M.D.		ADDRESS 49 Greene St. DATE SIGNED 9/25/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md	24a. REC'D BY REGISTRAR DATE SEP 26 '58
		24b. REGISTRAR'S SIGNATURE C. S. H. H. H.	



9701

CERTIFICATE OF DEATH

Reg. Dist. No.

09709

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 2½ HOURS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				d. STREET ADDRESS 1004 OLDTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle E. Last MULVEY				4. DATE OF DEATH Month SEPTEMBER Day 1 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6,		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME FRANK LEUCK				14. MOTHER'S MAIDEN NAME ANNA GAZENHOWER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterograde Heart Disease DUE TO Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Diabetes Mellitus (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May , 19 55 , to Sept 1 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at MD , from the causes and on the date stated above ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 9/2/58							
ACTUAL SIGNATURE George M. Simons M.D.				DATE SIGNED 9/2/58			
PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS				ADDRESS Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3702

CERTIFICATE OF DEATH

Reg. Dist. No.

09710

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & MEMORIAL HOSPITAL WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d. STREET ADDRESS 62 BOONE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LESTER MAHLON MYERS		4. DATE OF DEATH Month Day Year SEPT. 13, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1883
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) LEESBURG, VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MAHLON, MYERS		14. MOTHER'S MAIDEN NAME Mary Redman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-12-3275	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Posterior Myocardial Infarction DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Shock		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 12, 58 , to Sept. 13, 1958 that I last saw the deceased alive on September 13, 1958 , and that death occurred at 12:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 50 Pershing St. 9/13/58			
ACTUAL SIGNATURE <i>Samuel Jacobson</i> PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON		M.D. Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS SEP 16 '58	
24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detachable for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9703

CERTIFICATE OF DEATH

Reg. Dist. No.

99711

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 HOURS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		d. STREET ADDRESS 11 x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle ELLEN Last MYERS		4. DATE OF DEATH Month SEPTEMBER Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 28, 1957
9. AGE (In years last birthday) yrs. 9 Months 9 Days 9 Hours 9 Min.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HERBERT H. MYERS		14. MOTHER'S MAIDEN NAME RUTH IMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Congenital Heart DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-24-58 to 9-24-58 , that I last saw the deceased alive on 9-24-58 , and that death occurred at 4:10 P. M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 126 W. Main St. Md. DATE SIGNED 9-25-58	
ACTUAL SIGNATURE H. W. Eliason		PHYSICIAN'S NAME (Type) DR. H. W. ELIASON	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept 27-58	
22c. NAME OF CEMETERY OR CREMATORY Shont Run Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. C. Leighton		ADDRESS Oakland Md.	
24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE W. A. F. F. F.	

9704

CERTIFICATE OF DEATH

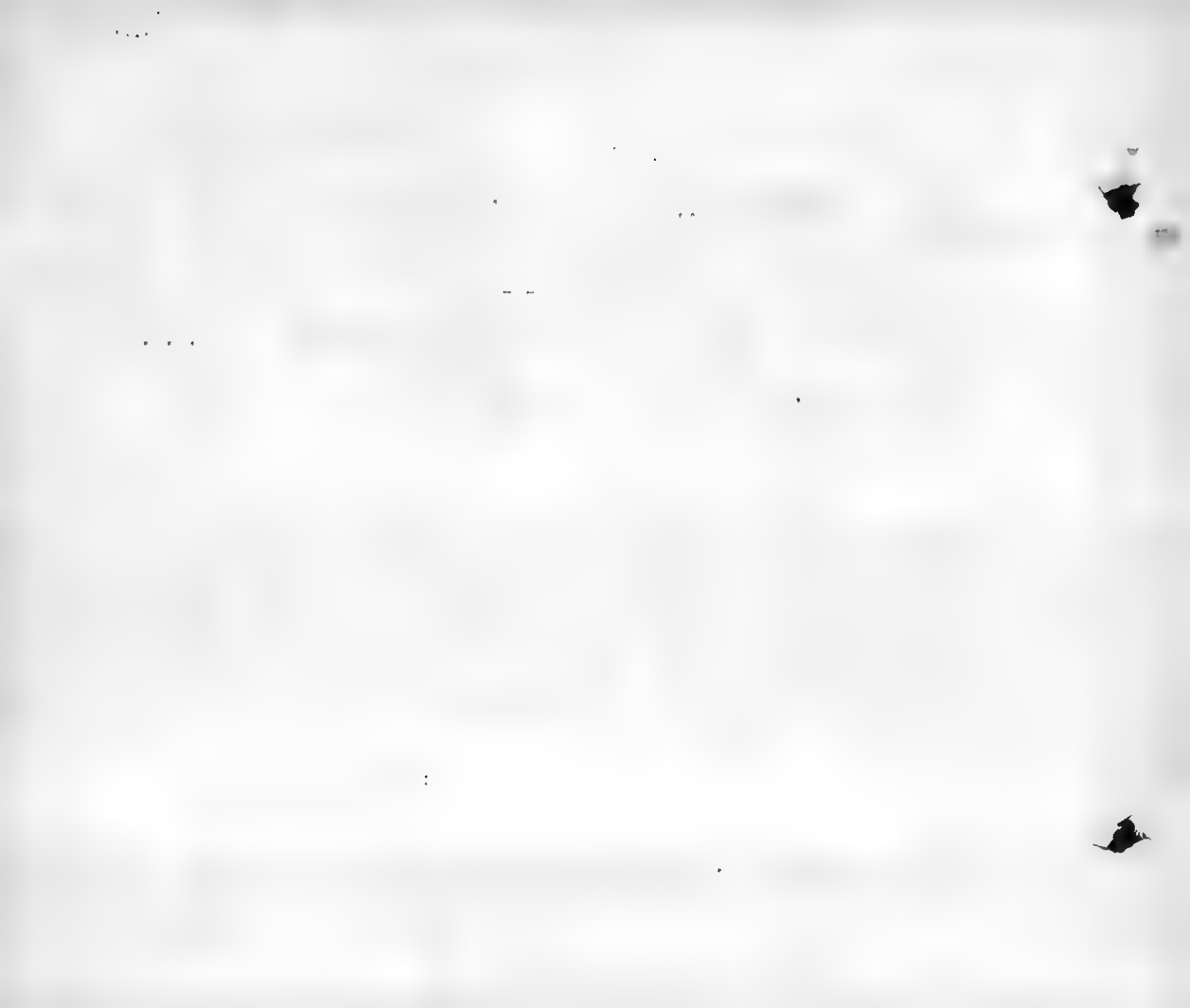
09712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b ONE DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN		Middle A	
Last NIES		4. DATE OF DEATH Month 9 Day 20 Year 1958	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-1888	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, never retire) Retired Self Contractor		12. KIND OF BUSINESS OR INDUSTRY Self	
13. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME JOHN A. NIES		16. MOTHER'S MAIDEN NAME CLARA SELL	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 235-30-0344	
19. INFORMANT Address Mrs. Hannah Nies Cumb. Md.		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4:20.0 DUE TO Compensatory Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic + Hypertensive Heart Disease (c) None	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis - Bronchial Asthma - Pneumonia		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
24c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		24d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24f. (City or town) (County) (State)	
25. I certify that I attended the deceased from Feb. , 19 58 to Sept 20 , 19 58 , that I last saw the deceased alive on Sept 19 , 19 58 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland, Md. DATE SIGNED 9-20-58			
ACTUAL SIGNATURE William P. James M.D.		26. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES	
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial		27b. DATE THEREOF 9/23/58	
27c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem.		27d. LOCATION (City, town, or county) (State) Cumberland Md.	
28. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		28a. ADDRESS Cumb. Md.	
28b. REC'D BY REGISTRAR SEP 22 '58		28c. REGISTRAR'S SIGNATURE William P. James	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09713

FOR STATE
HEALTH DEPT.

Items 8 & 9, File # 233 9/16/58.cac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb DCaA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh		d. STREET ADDRESS 5738 Kentucky Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		3. NAME OF DECEASED (Type or print) First Charles Middle W Last Pagan		4. DATE OF DEATH Month Sept Day 12 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1892	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter E. Pagan		14. MOTHER'S MAIDEN NAME Anna Bucher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Chas. W. Pagan		Address 5738 Kentucky Ave Pittsburgh, Pa.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Sept. 12, 1958					
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/58		22c. NAME OF CEMETERY OR CREMATORY Allegheny Cemetery		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pennsylvania		24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Items 8 & 9, Film G234, 10, 9, 18 fcy										
9724										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH o COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>5 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 E. Main Street</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie W. Porter</u>					4. DATE OF DEATH Month Day Year <u>September 9th, 1958</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>83 Sept. 11th, 1877</u>		9. AGE (In years last birthday) <u>74 11 yrs</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>Charles W. Porter</u>					14. MOTHER'S MAIDEN NAME <u>Maggie C. Beal</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Bertha M. Long, Frostburg, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>My partner was killed because</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>										
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____										
21. I certify that I attended the deceased from <u>7/8</u> , 19 <u>58</u> to <u>9/9</u> , 19 <u>58</u> , that I lost soul the deceased olive on <u>9/9/58</u> 12 _____, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Martin A. Rothstein</u> M.D.					ADDRESS (Street, city or town, state) <u>48 Carroll</u>					
DATE SIGNED <u>9/10/58</u>										
PHYSICIAN'S NAME (Type) <u>MARTIN A. ROTHSTEIN M.D.</u>					<u>Ex-170 C-11</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>					ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



9706

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/23/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans	
		f. STREET ADDRESS /	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle R. Last Price		4. DATE OF DEATH Month September Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1876
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Price		14. MOTHER'S MAIDEN NAME Sarah V. Creek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, chronic, 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic degenerative disease DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/23/58 , 19____, to 9/27/58 , 19____, that I last saw the deceased alive on 9/26/58 , 19____, and that death occurred at 3:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/27/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		ADDRESS 49 Greene St. DATE SIGNED 9/27/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL, ETC. Burial	22b. DATE THEREOF 9.29.58	22c. NAME OF CEMETERY OR CREMATORY Buck Valley Christian	22d. LOCATION (City, town, or county) (State) Buck Valley Fulton Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone Hancock m.c.		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09716

9742

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)
<u>Moscow</u> | | c. LENGTH OF STAY IN Tb
<u>3 Weeks</u> | | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)
<u>Moscow</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Marie</u> First <u>Ravenscroft</u> Middle Last | | | | 4. DATE OF DEATH
Month <u>September</u> Day <u>14</u> Year <u>19 58</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
<u>October 28, 1928</u> | | 9. AGE (In years last birthday)
<u>29 yrs</u> | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Wheeling, W. Va.</u> | | | |
| 13. FATHER'S NAME
<u>Bent Brown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Carl Ravenscroft</u> Address <u>Moscow, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) <u>Coronary sclerosis (left)</u>
DUE TO
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month. Day, Year <u> 19 </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Benedict Skitarelic</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<u>Sept. 14, 1958</u> | | | |
| EXAMINER'S NAME (Type)
<u>Benedict Skitarelic, M.D.</u> | | 22a. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | | | | | |
| 22b. DATE THEREOF
<u>9/17/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Calvary Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Wheeling, Wva.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>George Eichhorn</u> ADDRESS <u>Lonaconing, Md.</u> | | | | | | | |
| 24a. REC'D BY REGISTRAR
<u>SEP 16 58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9708 CERTIFICATE OF DEATH

Reg. Dist. No. 09717

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 9/2/58 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. STREET ADDRESS 118 Main Street | |
| 3. NAME OF DECEASED (Type or print)
First Blanche Middle L. Last Reece | | 4. DATE OF DEATH
Month September Day 12 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/22/1878 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR
Months 79 Days 79 Hours 79 Min 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Westernport, Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George Murphy | | 14. MOTHER'S MAIDEN NAME Louise Morris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. P.O.Box 599 | |
| 17. INFORMANT Allegany County Infirmary Records | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocardial Infarction | | | |
| 422.2 DUE TO Coronary Arteriosclerosis | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Spontaneous | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocardial Infarction | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/2/58 , 19___, to 9/12/58 , 19___, that I last saw the deceased alive on 9/11/58 , 19___, and that death occurred at 7:30 A. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dr. James E. McLean M.D. | | ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. | |
| DATE SIGNED 9/12/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/15/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Philop | | 22d. LOCATION (City, town, or county) (State) Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ed. J. Bond | | ADDRESS Westernport, Md. | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |
| DATE SEP 16 '58 | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09718

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

9707

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
Lifetime | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
414 E. Oldtown Road | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| f. STREET ADDRESS
414 E. Oldtown Road | | g. IS RES. OFN. E. ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Reichert Last Reichert | | 4. DATE OF DEATH
Month Sept. Day 25 Year 1958 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 17, 1869 |
| 9. AGE (In years last birthday)
89 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 | 11. IF UNDER 24 HRS
Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Julius Grabenstein | | 14. MOTHER'S MAIDEN NAME
Susan Leidinger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO
None | |
| 17. INFORMANT
Sr. Mary Leonita St. Mary's Convent | | Address
Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 0 m 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | DATE SIGNED
Sept. 25, 1958 | |
| EXAMINER'S NAME (Type)
Benedict Skitarelic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
9-29-58 | 22c. NAME OF CEMETERY OR CREMATORY
St. Peter & Paul Cem. | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | 24a. REC'D BY REGISTRAR
DATE SEP 30 '58 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 ~~X~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9743

CERTIFICATE OF DEATH

09719

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Barton | | | | c. LENGTH OF STAY IN 1b
78 Yr. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
John First Simons Middle Robertson Last | | | | 4. DATE OF DEATH
Sept. 11, 19 58 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar. 6, 1880 | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Rail-road | | 11. BIRTHPLACE (State or foreign country)
Barton, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 13. FATHER'S NAME
George Robertson | | | |
| 14. MOTHER'S MAIDEN NAME
Catherine Simons | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
712-14-1650 | | | | 17. INFORMANT
Mrs. Helena Robertson-Barton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Renal Disease.
442 X DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerosis. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs 5yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from June 15, 19 58 , to Sep 11, 19 58 , that I last saw the deceased alive on Sep 10, 19 58 , and that death occurred at 7 a. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James H. Wolverton Sr Md M.D. | | | | ADDRESS (Street, city or town, state) 20 Green St Piedmont W Va | | | |
| DATE SIGNED SEP 15 '58 | | | | 22. LOCATION (City, town, or county) (State)
Moscow Md. | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
9/13/58 | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. J. B. B. B. | | | | 23b. ADDRESS
Westernport, Md. | | | |
| 24a. REC'D BY REGISTRAR
SEP 15 '58 | | | | 24b. REGISTRAR'S SIGNATURE
Charles J. Hines | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 filed 9-24-58 10-1-58

CERTIFICATE OF DEATH

Reg. Dist. No.

09720

9744

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Midland | | c. LENGTH OF STAY IN lb
11 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
(Daughter's home) | | d. STREET ADDRESS
Barton | |
| 3. NAME OF DECEASED (Type or print)
First Alphus Middle Lee Last Ross | | 4. DATE OF DEATH
Month Sept. Day 20 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
Dec. 7, 1891 |
| 9. AGE (In years last birthday)
66 yrs | | IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal Mine | |
| 11. BIRTHPLACE (State or foreign country)
Barton, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
John Ross | | 14. MOTHER'S MAIDEN NAME
Emma Murphy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
no | | 16. SOCIAL SECURITY NO
(If yes, give war or dates of service) | |
| 17. INFORMANT
Mrs. Richard Davis-Baltimore, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331x DUE TO Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 weeks
DUE TO years
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 3, 19 58 to September 20, 19 58 , that I last saw the deceased alive on September 20, 19 58 , and that death occurred at 2:30 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2 B Roadway DATE SIGNED 9/22/58
ACTUAL SIGNATURE John B. Davis, M.D.
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostberg, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9/23/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill | | 22d. LOCATION (City, town, or county) (State)
Moscow Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. B. Bural | | ADDRESS
Westernport, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 25 '58 | | 24b. REGISTRAR'S SIGNATURE
C. L. L. H. H. | |

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

9725

CERTIFICATE OF DEATH

Reg. Dist. No.

09721

| | | | | | | | |
|--|--|---|-------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | | | d. STREET ADDRESS
Main Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Janette Middle Schweikert Last Schweikert | | | | 4. DATE OF DEATH
Month September Day 27 Year 19 58 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 6, 1881 | |
| 9. AGE (In years last birthday)
77 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 11. BIRTHPLACE (State or foreign country)
Lonaconing, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John McFarland | | | | 14. MOTHER'S MAIDEN NAME
Margaret Tennent | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO
None | | 17. INFORMANT
Kenneth Schweikert Staten Island, N.Y. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular of "son"
10/1X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March , 19 57 , to Sept. 27 , 19 58 , that I last saw the deceased alive on Sept. 27, 1958 , and that death occurred at M , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) MAIN ST DATE SIGNED 9-27-58 | | | | | | | |
| ACTUAL SIGNATURE Leslie R. Miles Jr. M.D. | | PHYSICIAN'S NAME (Type) LESLIE R. MILES JR M.D. LONA CONING MD. | | | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify)
Burial | | 22b. DATE THEREOF
9/30/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | | | ADDRESS
Lonaconing, Md. | | 24a. REC'D BY REGISTRAR
DATE OCT 2 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9709

CERTIFICATE OF DEATH

09722

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | | | d. STREET ADDRESS
521 Furnace St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Rose Shanski | | | | 4. DATE OF DEATH
Month Day Year
9 14 1958 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6/5/71 | |
| 9. AGE (In years last birthday)
87 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 11. BIRTHPLACE (State or foreign country)
Maryland, Cumberland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Hensler | | | | 14. MOTHER'S MAIDEN NAME
Mary Berg | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Paul Shanski Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident
/ X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/5 , 19 58 , to 9/14 , 19 58 , that I last saw the deceased alive on 9/14 , 19 58 , and that death occurred at 11:00 A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Leo H. Ley Jr. M.D. | | | | ADDRESS (Street, city or town, state)
456 N. Centre St. Cumberland, Md. | | | |
| DATE SIGNED
9/15/58 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9/17/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Sts. Peter & Paul Cath. | | 22d. LOCATION (City, town, or county) (State)
Cem. Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
SEP 18 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

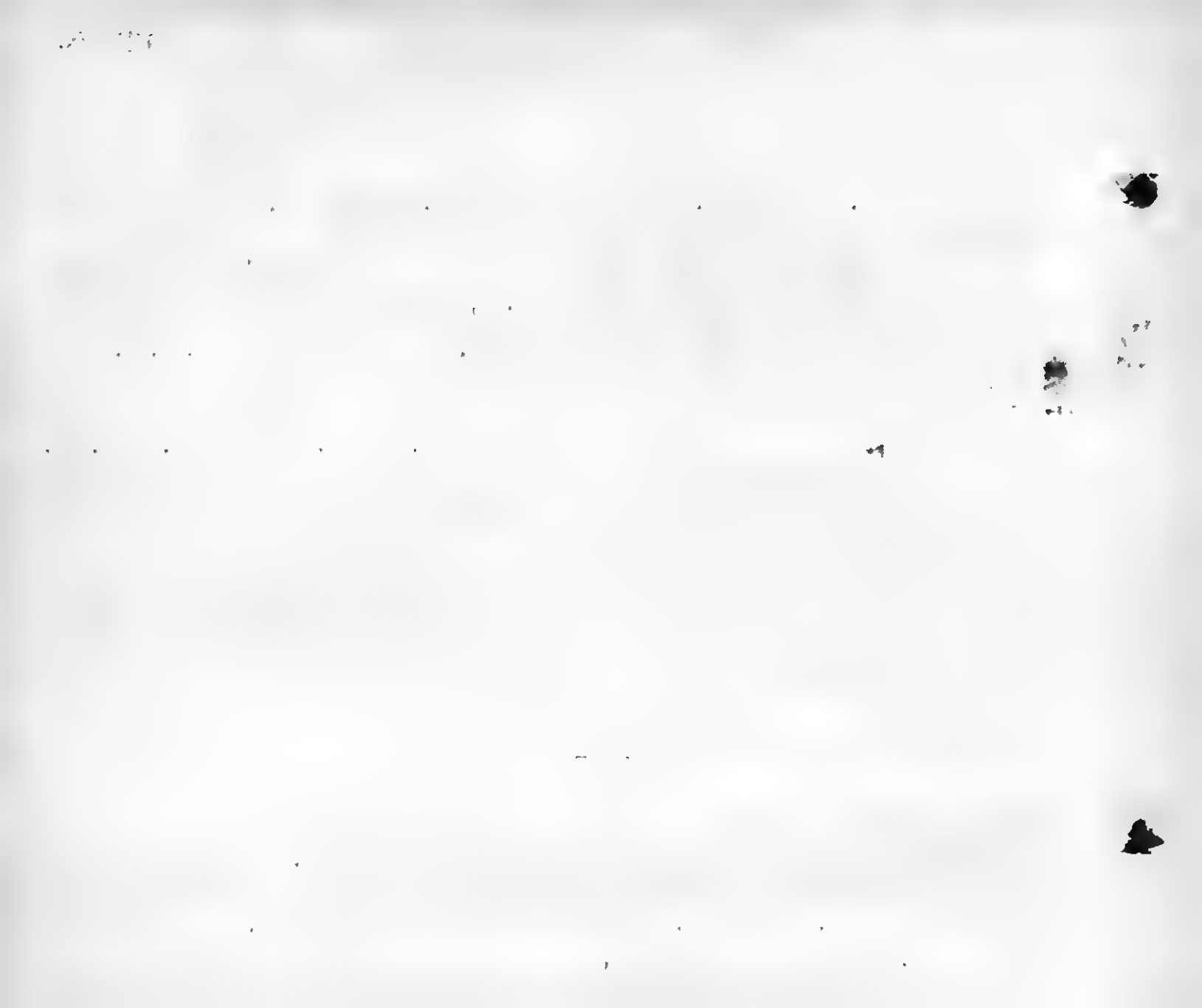
9710

CERTIFICATE OF DEATH

09723

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>117 So. Allegany St.</u> | | d. STREET ADDRESS
<u>117 So. Allegany St.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Martha</u> Middle <u>Elizabeth</u> Last <u>Sheeche</u> | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>10</u> Year <u>1958</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 9, 1836</u> |
| 9. AGE (In years last birthday)
<u>72</u> yrs | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | 11. BIRTHPLACE (State or foreign country)
<u>Fenna.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | |
| 13. FATHER'S NAME
<u>Henry Hatherill</u> | | 14. MOTHER'S MAIDEN NAME
<u>Caroline Meggs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Thomas Sheeche, 117 So. Allegany St. Cumb. Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO <u>Coronary Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u>
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-19-56</u> , 19 <u>9-10-58</u> , that I last saw the deceased alive on <u>9-10-58</u> , 19 <u> </u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ralph W. Ballin</u> | | ADDRESS (Street, city or town, state) <u>62 Greene St.</u> | |
| PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u> | | DATE SIGNED <u>9-11-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Sept. 13, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Bernards Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Indiana, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>SEP 15 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Keane</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9726

CERTIFICATE OF DEATH

Reg. Dist. No.

09724

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | e. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle A. Last Sigler | | 4. DATE OF DEATH
Month September Day 5 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 25, 1870 |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Miner | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal Mine | 11. BIRTHPLACE (State or foreign country)
Westernport, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | |
| 16. SOCIAL SECURITY NO
(If yes, give war or dates of service) | | 17. INFORMANT
Mrs. Francis Lease Address Midland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary Sclerosis
DUE TO Arterio Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
6 days
? | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 30 , 19 58 to Sept 3 , 19 58 , that I last saw the deceased alive on Sept 3 , 19 58 , and that death occurred at 9:55 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED Sept 1958
ACTUAL SIGNATURE W. O. McFarlane M.D. W. O. McFarlane
PHYSICIAN'S NAME (Type) W. O. McFarlane | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9/8/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Moscow, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 10 58 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanks | |



Item 20 Film 234 10-3-58
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9745

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)
<u>7 miles southeast of Flintstone</u> | | c. LENGTH OF STAY IN 1b
<u>Route 1, Oldtown,</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Rural near Flintstone</u> | | /d. STREET ADDRESS
<u>Routel</u> | |
| e. IS RESIDENCE ON A FARM
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Raymond Marcellus Slider</u> | | 4. DATE OF DEATH
Month Day Year
<u>September 23 1958</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 24, 1926</u> |
| 9. AGE (In years last birthday)
<u>31 yrs.</u> | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Farm</u> | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Marcellus L. Slider</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elenor Haugh</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>no</u> | |
| 17. INFORMANT
<u>Mrs. Raymond Slider Oldtown, Maryland</u> | | Address <u>Rt. 1</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushed Chest</u> 5 min. | | | |
| 835X DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (b) <u>Fractured skull</u> 5 min. | | | |
| (c) DUE TO | | | |
| cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (private bridge on farm)
<u>Bridge collapsed under tractor he was driving</u> | |
| 20c. TIME OF INJURY
Hour <u>2:30</u> P. M. Month, Day, Year <u>9/23/58</u> | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Farm</u> | 20f. (City or town) (County) (State)
<u>RFD#1 Oldtown Allegany, Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | DATE SIGNED <u>Sept 23, 1958</u> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>Sept. 26, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Burial Park</u> | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John J. Hafer, Cumberland, Maryland</u> | | 24a. REC'D BY REGISTRAR
DATE <u>SEP 26 '58</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kenna</u> |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09726

9711

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 20 mo., 20 das. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Smith Last Smith | | 4. DATE OF DEATH
Month September Day 3 Year 19 58 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 4, 1882 |
| 9 AGE (In years lost birthday) 75 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY Maryland |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13 FATHER'S NAME Peter Smith | | 14 MOTHER'S MAIDEN NAME Jennie Scott | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Alvin Ternent | | Address Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 333 chronic bronchitis
DUE TO 592X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) 443 Chronic independent hypertension
DUE TO 552 Chronic hypertension
(c) 305-1721 Chronic with psychotic reaction | | | INTERVAL BETWEEN ONSET AND DEATH
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
305-1721 Chronic with psychotic reaction | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 14, 1956 to Sept. 3, 1958 , that I last saw the deceased alive on Sept. 2, 1958 , and that death occurred at 10:24 M, from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE James E. McLean, M.D. | | ADDRESS (Street, city or town, state) 445.2000 St DATE SIGNED 9-3-58 | |
| PHYSICIAN'S NAME (Type) James E. McLean, M.D. | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/5/58 | 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | 22d. LOCATION (City, town or county) (State) Lonaconing, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn | | ADDRESS Lonaconing, Md | |
| 24a. REC'D BY REGISTRAR SEP 9 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knaus | |

9712

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
9 HRS. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MD. | | b. COUNTY
ALLEGANY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND CRESAPTOWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL, MEMORIAL AVE. | | | | | | e. STREET ADDRESS
11 MEADOW DRIVE | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
STEINBERGER | | | | | | 4. DATE OF DEATH
Month Day Year
SEPT 1 19 58 | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/1/58 | | 9. AGE (In years last birthday) yrs.
9 | | IF UNDER 1 YEAR
Months Days Hours Min.
9 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
RUDOLPH STEINBERGER | | | | | | 14. MOTHER'S MAIDEN NAME
GENEVA EX GUAS | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity (24 wks)
776X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:00 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Fuller B. Whitworth, Cumberland, MD 28 Sept 58 | | | | | | | | | | | |
| ACTUAL SIGNATURE Fuller B. Whitworth, Cumberland, MD | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF
Sept 2, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY
Memorial Hospital | | 22d. LOCATION (City, town, or county) (State)
Cumberland, MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |
| | | | | | | DATE SEP 4 '58 | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09728

FOR STATE
HEALTH DEPT.

Reg. Dist No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN TB 4 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--Cumb. Md. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W.Va.
b. COUNTY Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford, W.Va.
d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First Ronald Middle Scott Last Tabler | | 4. DATE OF DEATH
Month Sept. Day 7 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 9, 1958 |
| 9. AGE (in years last birthday) 29 | | 10. IF UNDER 1 YEAR: Months 2 Days 29 Hours 19 Min 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Ronald Tabler | | 14. MOTHER'S MAIDEN NAME Patty Rummer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO none | |
| 17. INFORMANT Memorial Hospital--Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adrenal Hemorrhage
DUE TO Waterhouse-Freiderichsen Syndrome
Conditions, if any, which gave rise to immediate cause (b) Waterhouse-Freiderichsen Syndrome
(c) Waterhouse-Freiderichsen Syndrome
DUE TO Waterhouse-Freiderichsen Syndrome
cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 Hrs. | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour 19 o. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | DATE SIGNED Sept. 7, 1958 | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-8-58 | 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | 24a. REC'D BY REGISTRAR SEP 9 '58 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9714

CERTIFICATE OF DEATH

Reg. Dist. No.

09729

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN 1b
<u>19 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>02 Cumberland</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS
<u>11 Independence St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Nannie</u> Middle <u>E.</u> Last <u>Tyree</u> | | | | 4. DATE OF DEATH
Month <u>9</u> Day <u>23</u> Year <u>58</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7/10/74</u> | |
| 9. AGE (n years lost birthday)
<u>84</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housekeeper</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Drain</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Not known</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Chart</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of spine</u>
<u>196.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. _____ p. m. _____
Month _____ Day _____ Year <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>8/30</u> , 19 <u>58</u> , to <u>9/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above | | | | | | | |
| ACTUAL SIGNATURE <u>R. M. Truaskis, Sr.</u> | | | | ADDRESS (Street, city or town, state) <u>Cumberland, Maryland</u> DATE SIGNED <u>9/24/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Truaskis, Sr.</u> | | | | 220 <u>Baltimore Ave.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>9/26/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Green Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Buena Vista, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ruth E. Silcox</u> | | | | ADDRESS
<u>Cumberland, Maryland</u> | | 24a. REC'D BY REGISTRAR
DATE <u>SEP 26 58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Harris</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9748

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09730

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u> | | | |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)
<u>Rural Cumberland</u> | | c. LENGTH OF STAY IN TB
<u>traveling</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Elk Garden</u> | | d. STREET ADDRESS
<u>Near Hartmansville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Route 5,</u> | | | | e. IS RESIDENT ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Hiram Eyra</u> Middle <u>Van Meter</u> Last <u>Sept. 13</u> | | | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>13</u> Year <u>1958</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OF RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept. 3, 1913</u> | |
| 9. AGE (In years last birthday)
<u>45</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Miner</u> | | 11. BIRTHPLACE (State or foreign country)
<u>W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Van Meter</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Minnie Rohrbaugh</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>236 12 9043</u> | | 17. INFORMANT
<u>Sharpless Funeral Home, Blaine, W. Va.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushed Skull</u>
823X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Overturnd in an Automobile</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
<u>Overturnd in an Automobile</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>5:00 p.m. 9/13 1958</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Street</u> | | 20f. (City or town) (County) (State)
<u>Rt. 220 Alleg. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPT. MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>9/16/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Maysville Cemetery</u> | |
| 22d. LOCATION (City, town, or county) (State)
<u>Blacksburg, W. Va.</u> | | | | 24a. REC'D BY REGISTRAR
<u>SEP 16 '58</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Light</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Huns</u> | | | |

MEDICAL CERTIFICATION

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or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2.

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9715

CERTIFICATE OF DEATH

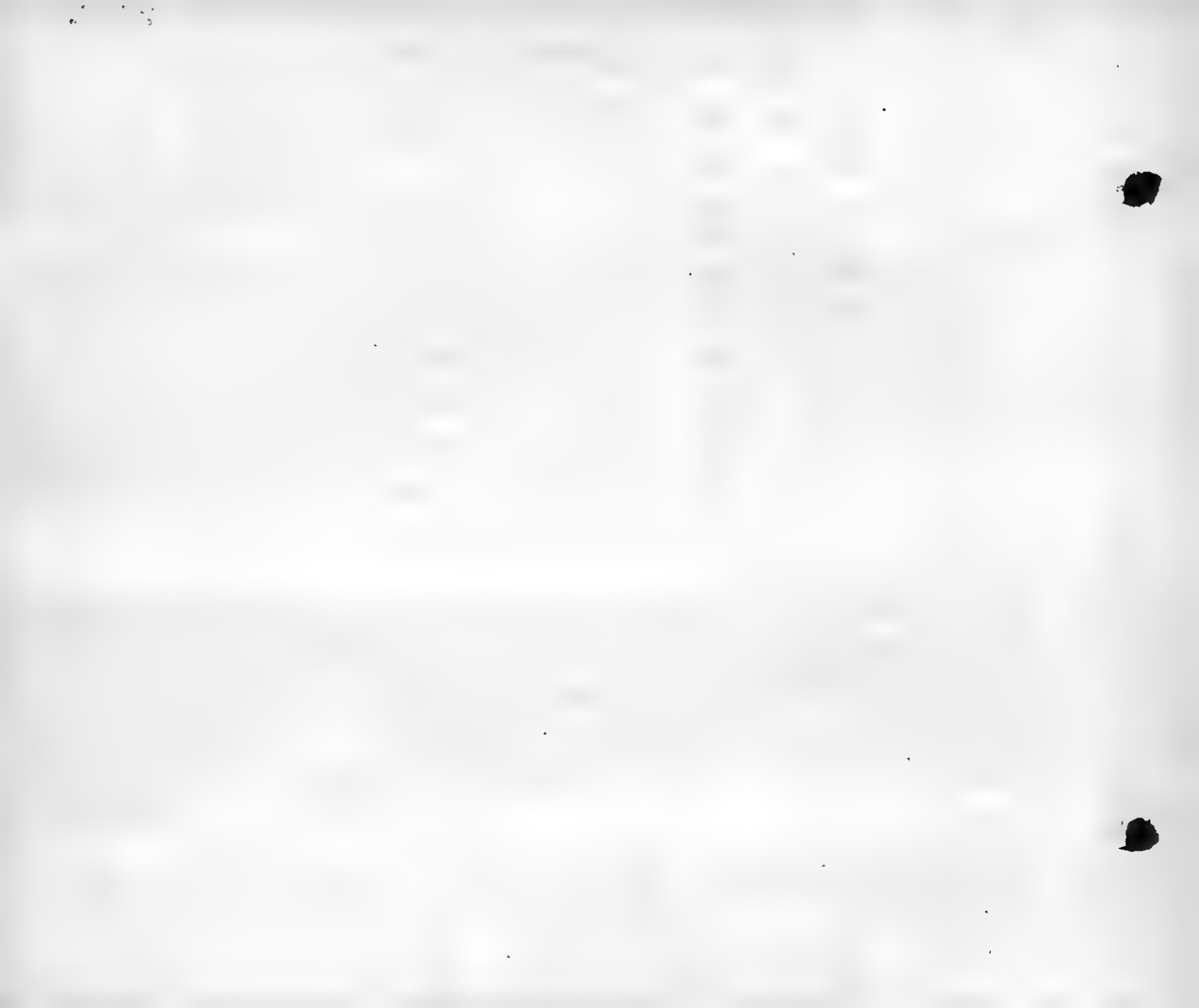
Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
32 years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | d. STREET ADDRESS
121 West First Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
121 West First Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Bessie Middle Lee Last Wakeman | | | | 4. DATE OF DEATH
Month 9 Day 2 Year 19 58 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-7-1894 | | 9. AGE (In years last birthday) yrs.
63 | 10. IF UNDER 1 YEAR
Months 6 Days 3 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY
School Cafeteria | | 11. BIRTHPLACE (State or foreign country)
Edinburg, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Benjamin G. Mc Inturff | | | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Bowman | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
220-10-7490 | | | | 17. INFORMANT
Address
Mr. Charles H. Wakeman, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of uterus
174X
DUE TO
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
187424 | | | | | | INTERVAL BETWEEN ONSET AND DEATH
187424 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour 19 Month 19 Day 19 Year 19
p. m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
220 Baltimore Ave. | | |
| 20f. (City or town)
Cumberland | | | 20g. (County)
Allegany | | | 20h. (State)
Md. | |
| 21. I certify that I attended the deceased from Aug 5th 1958 to Sept 2nd 1958 that I last saw the deceased alive on Sept 1st 1958 , and that death occurred at 8:15 M, from the causes and on the date stated above
ADDRESS (Street, city or town, state)
220 Baltimore Ave., Cumberland, Md.
DATE SIGNED
9-3-1958 | | | | | | | |
| ACTUAL SIGNATURE R. W. Trevaskis | | | | DATE SIGNED 9-3-1958 | | | |
| PHYSICIAN'S NAME (Type)
Dr. R. W. Trevaskis | | | | Cumberland, Md. | | | |
| 22a. BURIAL CREMATION, REMOVAL, (Specify)
Burial | | 22b. DATE THEREOF
9-5-58 | | 22c. NAME OF CEMETERY OR CREMATORY
Mc Inturff Cemetery | | 22d. LOCATION (City, town, or county) (State)
Fort Powells Valley, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE SEP 4 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hous | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

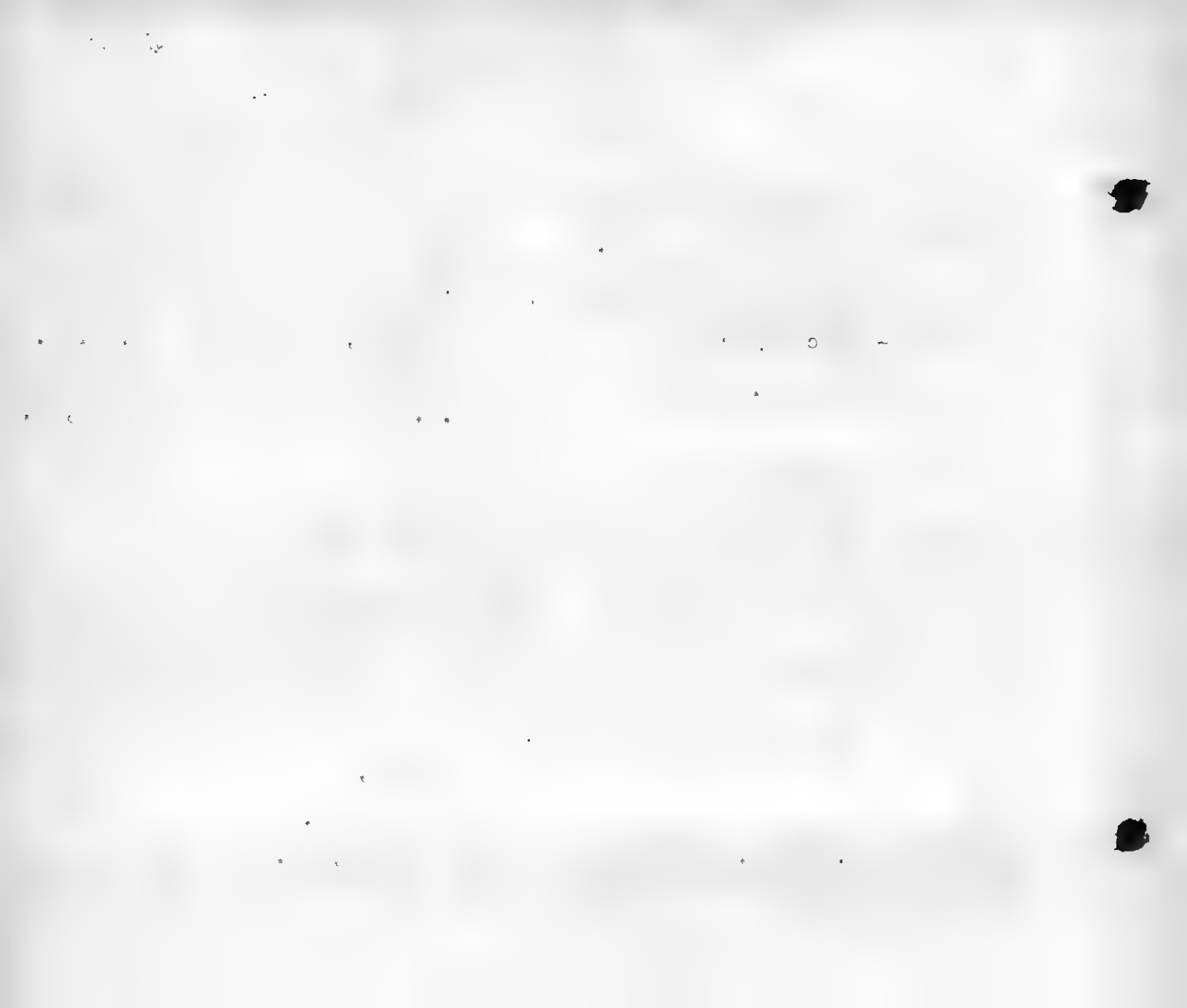
09732

3716

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
11/14/57 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | d. STREET ADDRESS
47 Linden Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Melvin Middle M. Last Ward | | 4. DATE OF DEATH
Month September Day 15 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/1/1871 |
| 9. AGE (In years last birthday)
87 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min | IF UNDER 24 HRS
Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - Bricklayer | | 10b. KIND OF BUSINESS OR INDUSTRY
Wellersburg, Pennsylvania | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Pinkney P. Ward | | 14. MOTHER'S MAIDEN NAME
Rebecca Gallagher | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT P.O. Box 599 | | Address Cumberland, Md. | |
| Allegany County Infirmary Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, chronic, Severe
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterio Sclerosis, Chronic, severe
DUE TO
(c) Arterio Sclerosis, & degeneration | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/14/57 , 19____, to 9/15/58 , 19____, that I last saw the deceased alive on 9/15/58 , 19____, and that death occurred at 10:30 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/16/58 | | | |
| ACTUAL SIGNATURE Dr. Lee B. Mathews M.D. | | ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 9/16/58 | |
| PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9-18-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, | | ADDRESS
Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 18 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

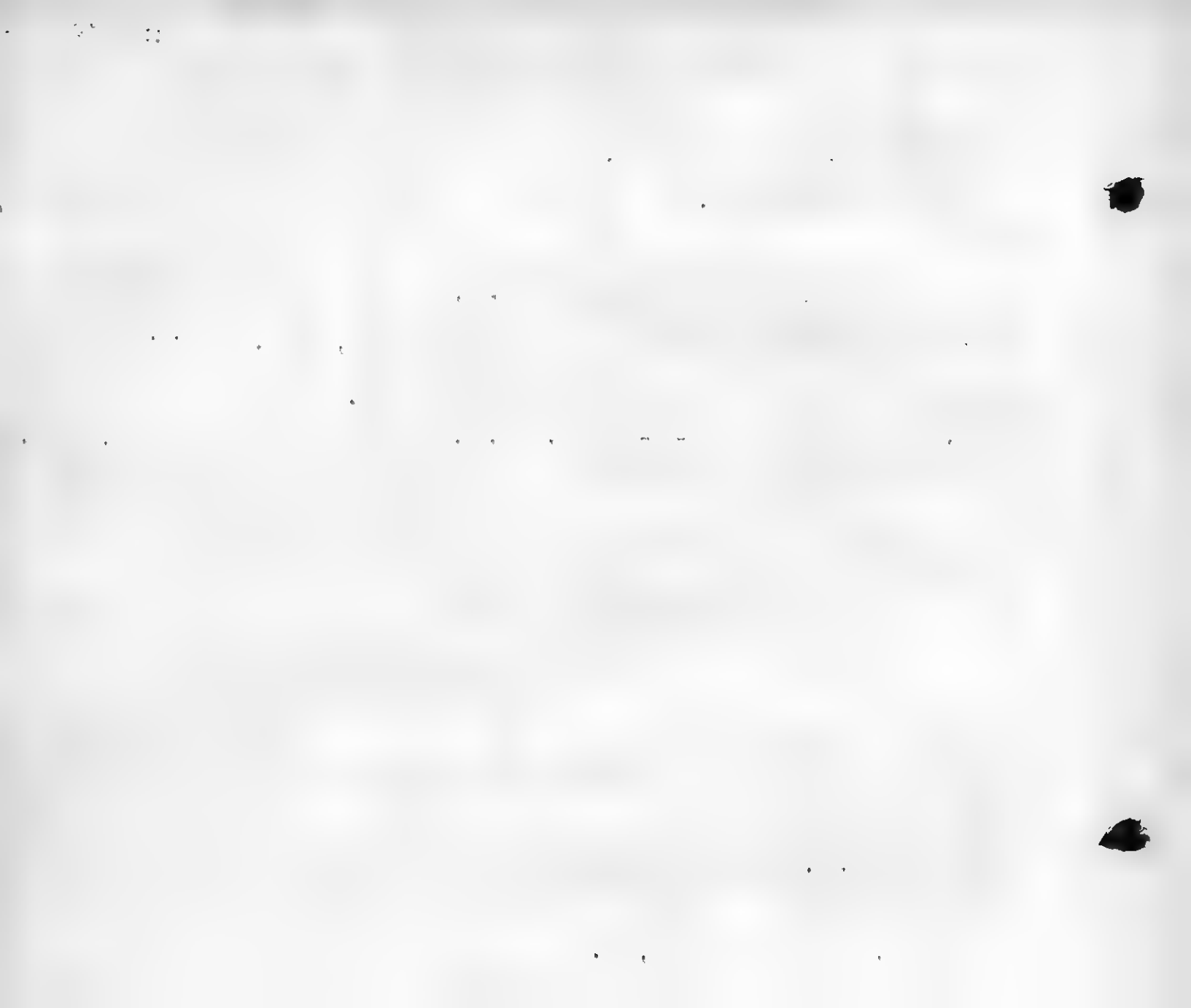
CERTIFICATE OF DEATH

Reg. Dist. No.

09733

9717

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN 1b
6 HRS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | d. STREET ADDRESS
910 HOLLAND STREET | | | |
| 3. NAME OF DECEASED (Type or print)
First MABLE Middle Imes Last WETZEL | | | | 4. DATE OF DEATH
Month SEPTEMBER Day 7 Year 19 58 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 3, 1983 | |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 1 Hours 1 Min. | | 11. BIRTHPLACE (State or foreign country)
Chaneysville, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed seamstress | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Tailoring | | 11. BIRTHPLACE (State or foreign country)
Chaneysville, Penna. | |
| 13. FATHER'S NAME
LEWIS IMES | | | | 14. MOTHER'S MAIDEN NAME
ANN BROWNING | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | | | 16. SOCIAL SECURITY NO
220-30-8503 | | 17. INFORMANT
Lt. Col. L. Leo Morrissey Address 910 Holland St., Cumb. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
434.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
8 hrs
5 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 9-6 , 19 58 , to 9-7 , 19 58 , that I last saw the deceased alive on 9-7 , 19 58 , and that death occurred at 10:55 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 441 N. Center St., Cumb. DATE SIGNED 9-7-58 | | | | | | | |
| ACTUAL SIGNATURE William J. James M.D. | | | | DATE SIGNED 9-7-58 | | | |
| PHYSICIAN'S NAME (Type) W. P. JAMES | | | | Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
9/10/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George Address Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE SEP 15 '58 | | 24b. REGISTRAR'S SIGNATURE
William J. James | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09734

9727

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Center St. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | |
| | | d. STREET ADDRESS 232 Center St. | |
| 3. NAME OF DECEASED (Type or print) Charles Isaac Williams | | 4. DATE OF DEATH 27 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 2 1877 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR: Months 27 Days 19 Hours 58 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Brick Yard | |
| 11. BIRTHPLACE (State or foreign country) Frostburg, Md. | | 12. CITIZEN OF WHAT COUNTRY: U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Rosa A. Williams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-10-7326 | |
| 17. INFORMANT Idea Belle Gordon | | Address Frostburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency
4x2x1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO
(c) ? | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
White Not white
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 1, 19 18 to Sept 27, 19 58 , that I last saw the deceased alive on Sept 26, 19 58 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above
ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED Sept 24 1958 | | | |
| ACTUAL SIGNATURE WOMC Lane | | M.D. WOMC Lane | |
| PHYSICIAN'S NAME (Type) WOMC Lane | | MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-30-1958 | 22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg Md. | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Haier | | 24a. REC'D BY REGISTRAR Oct 1 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur E. Kraus | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

Reg. Dist. No.

09735

9728

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rt. 1, Frostburg</u> | | c. LENGTH OF STAY IN 1b
<u>9 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rt. 1, Vale Summit, Frostburg</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Dessie</u> Middle <u>Winebrenner</u> Last <u></u> | | | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>3rd</u> Year <u>19 58</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 13th, 1888</u> | | 9. AGE (In years last birthday)
<u>70 yrs.</u> | IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min <u></u> | IF UNDER 24 HRS
Months <u></u> Days <u></u> Hours <u></u> Min <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>own housework</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Dennis LaRue</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Hannah McKenzie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>215-15-9930</u>
<u>None</u> | | 17. INFORMANT
Address <u>Samuel Winebrenner, Rt. 1, Vale Summit, F'bg</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u>
<u>151X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic myocarditis & Hypertrophy</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month <u></u> Day <u></u> Year <u>19</u>
Hour a. m. <u></u> p. m. <u></u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>58</u> , to <u>August 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 8</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>48 Broadway, Frostburg, Md.</u> DATE SIGNED <u>9/4/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Hilda Jane Walters</u> | | M.D. <u>Hilda Jane Walters, M. D.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>9-6-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Johnson Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Garrett County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph R. Durst</u> | | | | ADDRESS
<u>Frostburg, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>SEP 8 58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hand</u> | | | |

9729

CERTIFICATE OF DEATH

09736

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | e. STREET ADDRESS
Mt. Savage | |
| 3. NAME OF DECEASED (Type or print)
First GAIL Middle E. Last WINEBRENNER | | 4. DATE OF DEATH
Month Sept. Day 4 Year 1958 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 1, 1958 |
| 9. AGE (In years last birthday) yrs 3 | | 10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min 3 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
infant | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Fred Winebrenner | | 14. MOTHER'S MAIDEN NAME
Virginia Martin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
none | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Fred Winebrenner, Mt. Savage, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 270x DUE TO Childbirth - 7 days after birth | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none DUE TO (c) none | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 1, 1958 , to Sept. 4, 1958 , that I last saw the deceased alive on Sept. 4, 1958 , and that death occurred at 5:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Martin Rothstein, M.D. | | DATE SIGNED 9/5/58 | |
| PHYSICIAN'S NAME (Type) Martin Rothstein, M.D. | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
9-5-58 | 22c. NAME OF CEMETERY OR CREMATORY
Methodist Cemetery | 22d. LOCATION (City, town, or county) (State)
Mt. Savage, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, | | ADDRESS
Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 8 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hanks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9718 CERTIFICATE OF DEATH

09737

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
615 Sedgwick Street | | d. STREET ADDRESS
615 Sedgwick Street | |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle Jacob Last Winfield | | 4. DATE OF DEATH
Month Sept. Day 30 Year 1958 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 31, 1886 |
| 9. AGE (In years lost birthday) yrs. 72 | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Tin Mill | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY
USA | |
| 13. FATHER'S NAME
John J. Winfield | | 14. MOTHER'S MAIDEN NAME
Catherine Liobel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO
218-30-0384 | |
| 17. INFORMANT
Mrs. Leo Palmer | | Address
Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal aneurysm
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
0 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 7-21, 1958 , to 9-30, 1958 , that I last saw the deceased alive on 9-30, 1958 , and that death occurred at 6 P.M. , from the causes and on the date stated above
ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md.
DATE SIGNED 10-2-58 | | | |
| ACTUAL SIGNATURE
Ralph W. Ballin | | M.D. 62 Greene St. Cumberland, Md. | |
| PHYSICIAN'S NAME (Type)
Ralph W. Ballin | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Oct. 3, 1958 | 22c. NAME OF CEMETERY OR CREMATORY
SS. Peter & Paul | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
DATE OCT 6 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. House | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

Reg. Dist. No.

9719

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN 1b <u>5 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>223 Baltimore Street</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>
d. STREET ADDRESS <u>223 Baltimore Street</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Gertrude E. Wise</u> | | | | 4. DATE OF DEATH Month Day Year
<u>September 20, 1958</u> | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 18, 1893</u> | | 9. AGE (In years last birthday) <u>65</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Stores Hyndman Pa</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Robert DeVore</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Christine Rice</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>220-16-5967</u> | | 17. INFORMANT
<u>Edwin Robt Wise - 261 Kent Drive</u>
<u>Manassas Park Pa</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>440.1</u> DUE TO <u>Coronary Sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 hrs.</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarolic</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarolic M.D.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 20, 1958</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Sept 23, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Hyndman Pa</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u> | | | | | | 24a. RECEIVED BY REGISTRAR <u>SEP 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Christ S. Thayer</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

113

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9720

Reg. Dist. 80739

FOR STATE
HEALTH DEPT.

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN TB 10 Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE W.Va. b. COUNTY HAMPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta 85x-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Audrey Middle J. Last Wolfe | | 4. DATE OF DEATH
Month Sept. Day 23 Year 1958 | |
| 5. SEX
F. | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 20 1912 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME
James Daugherty | | 14. MOTHER'S MAIDEN NAME
LETA SAVILLE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mem. Hosp. | | Address
Cumberland Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
916.2 IMMEDIATE CAUSE (a) Third and Fourth Degree Burn Burns,
DUE TO Generalized
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause lost. DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Kerosene burns | |
| 20c. TIME OF INJURY Month, Day, Year
9:00 AM 9/23/ 1958 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Augusta (County) (State) W.Va. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/26/1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Ignace | | 22d. LOCATION (City, town, or county) (State) Augusta Rural | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. H. McKee ADDRESS Augusta | | 24a. REC'D BY REGISTRAR SEP 26 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | DATE SIGNED Sept. 23, 1958 | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05730

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

09740

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
15 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miners Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARIA Middle ZUMPARNO Last ZUMPARNO | | 4. DATE OF DEATH
Month Sept Day 2 Year 1958 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-16-1878 |
| 9. AGE (In years last birthday) yrs. 80 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 80 Days 80 Hours 80 Min. 80 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housework | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Peter Arnone | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 220-10-2155A | |
| 17. INFORMANT
Mrs. Anthony Zumpano, Frostburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial insufficiency
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
46 mo
7 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes
260x | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1 , 19 58 , to Sept 2 , 19 58 , that I last saw the deceased alive on Sept 1 , 19 58 , and that death occurred at 1:20 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE WOMC Lane M.D. | | ADDRESS (Street, city or town, state) Frostburg Md | |
| PHYSICIAN'S NAME (Type) WOMC Lane MD | | DATE SIGNED Sept 2 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
9-4-58 | 22c. NAME OF CEMETERY OR CREMATORY
St. Michaels Cemetery | 22d. LOCATION (City, town, or county) (State)
Frostburg, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. Durst, | | ADDRESS
Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR
DATE SEP 5 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneiss | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

Form No. 10-1

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED
 [Faint, illegible text]</p> | | <p>2. SEX
 [Faint, illegible text]</p> | |
| <p>3. AGE
 [Faint, illegible text]</p> | | <p>4. DATE OF BIRTH
 [Faint, illegible text]</p> | |
| <p>5. PLACE OF BIRTH
 [Faint, illegible text]</p> | | <p>6. DATE OF DEATH
 [Faint, illegible text]</p> | |
| <p>7. PLACE OF DEATH
 [Faint, illegible text]</p> | | <p>8. CAUSE OF DEATH
 [Faint, illegible text]</p> | |
| <p>9. MANNER OF DEATH
 [Faint, illegible text]</p> | | <p>10. SIGNATURE OF PHYSICIAN
 [Faint, illegible text]</p> | |
| <p>11. SIGNATURE OF REGISTRAR
 [Faint, illegible text]</p> | | <p>12. SIGNATURE OF WITNESS
 [Faint, illegible text]</p> | |